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Holes in the health care safety net: an ethnographic study of a free medical clinic

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Holes in the health care safety net: An ethnographic study of a free medical clinic

by

Pamela Ann Duffy

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Education

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Ames, Iowa

2008

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DEDICATION

In memory of Stephen C. Gleason, D.O. (1946-2006), friend and colleague.

He tried to change the world by changing health care.

He succeeded more than he ever knew.

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ABSTRACT

The purpose of this dissertation is to provide insight into the patient and volunteer perspective of their experiences at free medical clinics and, from the analysis of those data, inform health professions education. Many uninsured and underserved patients use the free clinic as their medical home to manage acute and chronic conditions and as a source of prescription medications. The volunteers find their experiences to be a fulfillment of their desire to give back to their community, a way to meet an obligation of professional duty, and hold to the moral belief that they should help those in need. Feminist methodologies and methods consistent with qualitative inquiry were used for data collection and analysis. I propose a pedagogical model to inform cultural competency training in health professions education based on feminist intersectionality theory as the grounding. Patients seeking health care services need to be viewed by health care practitioners and volunteers beyond simplistic demographics and medical conditions. The patient's everyday life cannot be explicated without orienting the health care encounter toward the complexity of the individual's multiple subjectivities and intersecting locations of oppression and subordination. Patient-centered care should strive to create space and time for explicating a rich cultural understanding of the patient. Culturally sensitive health care interventions are derived from this dialogic process. Equally important to the application of this model is the integration of this pedagogy in professional development programs for academic and clinical faculty who serve as role models and preceptors for health professions students.

CHAPTER 1 GENERAL INTRODUCTION

Background

The United States health care system, based on a market economy, is sometimes referred to as “corporate welfare” because health insurance coverage in this country is inextricably linked to employment. With the exception of federal programs such as Medicare and Medicaid (i.e., Title XIX), most individuals and families who have health insurance are covered as part of their compensation and benefit package at their job. But even this previously dependable form of access to health insurance is becoming less affordable. Current trends in employer sponsored health insurance programs are to pass on premium increases to the employees, rather than going to the corporate bottom-line. However, increased premiums do not translate to increased coverage, access, affordability, or outright richer health care benefits. Rather, health care coverage is becoming less comprehensive, employers are faced with a trend of annual double-digit increases in premiums, and more employees are opting out of insurance benefits (Steinberg, 2004).

Shifting rising health care costs to employees means that more and more of total family or individual income is required for co-insurance and co-payments. Rising health care costs are outpacing wages, and discretionary income is relatively lower for most workers (DeNavas-Walt, Protor, & Smith, 2007). Some employers are increasing the threshold of eligibility for workers to be eligible for company sponsored health insurance benefits. For example, if workers were previously eligible for health insurance on a part-time basis, now they may be required to work near or at full-time hours for the same benefit. Some young workers opt out of insurance programs at the workplace because the employee portion of

monthly insurance premiums is so large as to make it impossible to pay for housing and other costs of living and health insurance at the same time. Thus, even when health insurance is available, it may be financially unfeasible.

The health care picture is even bleaker for families living in poverty or at near-poverty levels. During the last 2 to 3 years, the numbers of individuals in the United States living in poverty remained steady at 36.5 million, but the number of uninsured has grown to over 47 million (DeNavas-Walt, Proctor, & Smith, 2007). State and federal safety nets for the underserved have gradually been diminished through policy changes such as the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL104-193) and decreased funding of state Medicaid programs, and as noted previously (Engel, 2006). One of the federal strategies to address the health care needs of the uninsured and underinsured has been the funding of Access Points under the Bureau of Primary Care's Community Health Center program (Health Resources Services Administration, 2005). Yet, in spite of this effort, there is growing evidence that these health care centers are not meeting the needs of the uninsured or underinsured, and the role for the free medical services provided by volunteers and contributions continues to grow (Freking, 2005; Geller, Taylor, & Scott, 2004; Knightly & Carrier, 2005) .

Dissertation Overview and Organization

This dissertation research provides insight into how free clinics function in the context of an inadequate health care system. This qualitative study is an ethnography of a free medical clinic in the Midwest with three distinct areas of inquiry. The first significant area of focus is on free clinic patients who are without access to regular, adequate health care, including those who are homeless, and the impact that the community based health care

services have on their everyday lives. The second emphasis is on the data from volunteers who deliver the health care services. This group of participants includes health care professionals and nonmedical lay volunteers who volunteer at the free clinic on a regular basis. I used interpretative methodologies to gain a greater understanding of the perspective of patient and volunteer participants from the participant free clinic. Lastly, the major significant findings from the patients and volunteers are useful in the context of how they can inform the pedagogy of preservice health professions education programs. That is to say, the patient and volunteer perspectives on the meaning of their experiences in and around the free clinic, lead to new strategies for enhancing transformative learning in cultural competency training in health professions education.

This dissertation research contributes to the literature on service learning, i.e. the community-based partnerships with academic medical centers and health professions education programs, by discussing how cultural competency training can be enhanced and better coordinated (Black, 2002; Dogra, 2001; Gaver, Borkan, & Weingarten, 2005; Gyllensten, Gard, Salford, & Ekdahl, 1999). The patient and volunteer perspectives from Chapters 2 and 3 then inform the new educational pedagogy presented in Chapter 4 (Kagawa-Singer & Kassim-Lakha, 2003) by illuminating the concept of multiple subjectivities (Bloom, 1998) and intersectionality of patients (Collins, 2000; McCall, 2005, Williams, 1994). The complexity of patients must be understood, respected, and acknowledged by health professionals to truly provide patient-focused health care.

My research is represented in three research articles organized by patient perspectives, volunteer perspectives, and curriculum application. I will proceed to discuss each of the subsequent chapters in greater detail. Chapter 2, “Holes in the Health Care Safety

Net: Voices of the Underserved,” was published in the Special Edition on Service Learning in the *Journal of Physical Therapy Education* (Duffy, 2006). This research paper explores the patients’ everyday lives and meaning-making of their experiences in a free medical clinic. This article focuses on the most significant gap in the current literature on free health clinics and service learning literature—the patient perspective (Geller et al., 2004). Secondly, it draws upon these data as applicable to teaching health care professions students the necessary skills and cultural sensitivity required for addressing issues facing vulnerable populations (Levi & Walens, 2001; Shipengrover & James, 1999). By gaining understanding of the patient perspectives of and experiences with the volunteers and medical services they receive, this research explicates the complexity of patient lives and experiences in the context of the current health care system. This chapter also provides insights on patient perceptions and experiences with “regular” health care as expressed in the semi-structured interviews.

Chapter 3, “Holes in the Health Care Safety Net: The Free Clinic Volunteer Experience,” focuses on the volunteer staff perspective of the role of free medical clinics. This research used volunteer lay and professional staff data to gain insight into their perspectives of the meaning they construct of their volunteerism. The meaning that volunteers construct around their volunteerism is varied. In addition, the volunteer perspectives were important in understanding the experiential learning that occurs in community-based internships such as those at free medical clinics. An identified gap became apparent during the participant observation experience related to the coordination of the experiential learning between the academic medical center and the free clinic on behalf of the medical and nursing students that rotate through the clinic. The volunteers reported the importance of treating patients with respect and caring. Yet the clinic volunteers did not

intentionally consider the multiple subjectivities of the patients which likely would have benefited the patients' coordination of care. The volunteers experienced conflict over the increasing demand in the amount and type of services from patients and their stated mission to provide "stop-gap" health care services.

Chapter 4, "Listening to Their Voices: Patients as Teachers," explores how the transformative aspects of experiential learning (Dogra, 2001; Gaver et al., 2005) can be enhanced through a new pedagogy that uses Intersectionality Theory as a basis of understanding patient lives (Collins, 2000; McCall, 2005; Williams, 1994). Community-based primary care settings, such as those found at free clinics, afford service learning opportunities with patients of diverse backgrounds. Teaching health professions students how to understand and appreciate those backgrounds and what they bring to the health care setting is a key to cultural competence training.

Purnell's Model of Cultural Competence is referenced as one theoretical framework for understanding the complexity of patient lives and patient-professional relationships (Purnell & Paulanka, 2005, pp. 6-19). Purnell and Paulanka (2003, 2005) described 12 domains essential to understanding patients in a transcultural health care setting. Pertinent domains for this ethnography are directly related to communication, family roles, workforce issues, health care practices, and health care practitioners. However, models such as Purnell's must be employed in a way that does not reduce the individual patient to a set of characteristics, but rather, see the patient's background in the context of their social relations. Therefore, most importantly, Chapter 4 addresses a significant pedagogical gap in health professions education programs related to the necessity to infusing feminist understandings of the complexity and standpoint of their everyday lives into health professions education.

This new pedagogical paradigm is grounded in Intersectionality Theory as foreground and Purnell's model of cultural competence as background. Using the lens of Collins' (2000) matrix of domination allows the health care practitioner the opportunity to view the social relationship with the patient from the standpoint and multiple oppressions of marginalized groups. This perspective enriches the communication and mutual understanding necessary to the patient–professional relationship. This nexus of feminist theory and cultural competency training helps address three longstanding dilemmas of the health care crisis as: (a) the inadequate numbers of health professionals from diverse backgrounds to treat diverse populations, (b) disparities in health care outcomes for patients from racial and ethnic minority groups, and (c) the perpetuation of bias and discrimination in the treatment of individuals from underserved and uninsured backgrounds.

As I summarize how the ethnographic data obtained from field notes and participant interviews, I also want to point to the inherent contradictions and limitations that these data expose. First of all, the patient data in Chapter 2 presents some of the patients' own conflicts around seeking care at the free clinics. Which it to say, patients appreciate the human respect and caring they experience in the manner in which the health care is provided, but at the same time, want to the complexity of their lives to also be appreciated. Nonetheless, the free clinic is preferable to regular health care because of how they are treated. As described in Chapter 3, the volunteers themselves recognize the limitations in the type and amount of health care they are being asked to provide, but are in conflict over how to meet the comprehensive medical needs of more patients with chronic disease. The free clinic setting itself can be physically and emotionally demanding of volunteers themselves, but they feel rewarded for the services they provide in the knowledge they are appreciated, even it if not

all that would normally be provided in another setting. However, they accept that whatever service they provide is better than no care at all, even if it does not always the ideal. They do the best they can, but are not organized to address take some of the requisite time required to consider complexity of patients' lives or complex medical conditions. Finally, in Chapter 4, through the analytic lens of Intersectionality Theory, two patient vignettes explore how these conflicts can potentially lead to untoward events, produce unresolved contradictions, and point toward the need for re-evaluation of how health care and experiential learning in free clinics are organized.

Methodology

Methodology is linked to beliefs about reality and constructs of knowledge production. From a broad perspective qualitative methodologies are interpretative in nature and rooted in sociology and anthropology (Denzin & Lincoln, 2000). As ethnography, my research is designed to gain an in-depth understanding of events and life experiences of patients and volunteers within and surrounding a community-based primary care free medical clinic. In this study, I use feminist methodologies to inform my understanding of the everyday lives and life concerns of underserved individuals and their experiences at free medical clinics. Feminist qualitative research methodologies are most appropriate to this study because of the unique characteristics of the researcher–participant relationship and the focus on improving social injustices (Adams, 2000; Bloom, 1998).

Feminist Methodologies

Feminist methodological approaches are varied and evolving and rooted in the examination of power relationships, social roles, and institutions by gender and sex. When inequities are observed and explicated in feminist research, remedies are often sought for the

injustices to the participants (Morawski, 2001). Often criticized for being overly subjective and lacking scientific rigor in the 1970s and 1980s (and earlier), feminist research has more recently received recognition for emphasizing underlying biases in previous research and warranting claims through “strong objectivity” in data analysis (Harding, 1992). As I seek to gain understanding of the full context of patient lives and circumstances, it is the collaborative aspects of feminist methodologies that are fundamental to this purpose.

Many feminist researchers agree that feminist methodology is unique in its desire and practice to disrupt the traditional and unspoken power inequity in the participant–researcher relationship (deLaine, 2000). Bloom (1998) expounded on the more interpersonal and reciprocal qualities of the participant-researcher relationship in feminist methodology:

1. Feminist methodology should break down the one-way hierarchical framework of traditional interviewing techniques. Feminist interviews should be engaged, interactive, and open-ended. Feminist interviews should strive for intimacy from which long-lasting relationships may develop. Feminist interviews are dialogic in that both the researcher and the respondent reveal themselves and reflect on these disclosures.
2. Feminist researchers give focused attention to and non-judgmental validation of respondents’ personal narratives.
3. Feminist researchers assume that what the respondents tell is true and that their participation is grounded in a sincere desire to explore their experiences.
4. In feminist methodology, the traditional “stranger–friend” continuum may be lengthened to be a “stranger–friend–surrogate family” continuum, which can allow

the connection between women to be a source of both intellectual and personal knowledge.

5. Identification with respondents enhances researchers' interpretative abilities, rather than jeopardizes validity. . . .
6. Feminist researchers strive for egalitarian relationships with their respondents by making space for them to narrate their stories as they desire; by focusing on issues that are important to respondents; by returning transcripts to the respondents so they can participate in interpretation; and by respecting the editorial wishes of the respondents regarding the final product or text. (pp. 17-18)

With these tenets in mind, the feminist researcher is venturing into inquiry that is open to possibilities and less concerned with control and distance than with equality, reciprocity, and relationship-building.

Feminist methodologies are also concerned with the social construction of knowledge through understanding the salient issues in the lived realities of women and girls. This principle also applies to any participant group that does not belong to or identify with the dominant culture of the society (Smith, 1987). By listening to the stories of uninsured and underinsured adults, I will glean insight into the patient's perspective of the experience in the health care system, as well as the perceived attitudes and behaviors of the health care practitioners in community-based free health clinics.

Dorothy Smith (1987) used the sociological terminology of "problematic" to posit a methodology that goes beyond the everyday experiences of the women, to the environment, and institutional/policy influences that shape women's experiences. Feminist methodology

invokes the researcher to be immersed in the world of the participants, not just observe it from a distance as other interpretivist methodologies suggest.

Bloom (1998) also approached these lived experiences from the construct of multiple subjectivities or the non-unitary subjectivity of the participant. For women, multiple identities, roles, feelings, and motivations can reside within the women simultaneously and cannot be teased apart from each other by the researcher as a skilled surgeon might dissect an organ. It is the holistic viewpoint of the subject that is some of the essence of feminist methodology so necessary for this research on uninsured and underinsured.

Smith's (1987) research and writing around everyday lives as interrelated with environment influences revealed institutional and public policy influences on the lives of women. It is the deeper study of the complexities of underserved and vulnerable individuals through feminist methodologies that will inform public health policy makers and health care educators about the limitations, restrictions, and impact of imposed solutions on the lives of individuals trying to survive.

Patient participants in this study included men, yet feminist methodological approaches are applicable to all vulnerable and marginalized individuals, not just women and girls. Feminist methodology seeks to examine everyday lives of people in nondominant positions in society, as well as the institutions and environments that have impact on them through the lens' of gender and power. The process of knowledge production that occurs recognizes the multiple roles and influences on individuals and strives to empower them and transform society.

Because this study is intended to influence curriculum in academic medical centers, it is important to note that feminist methodologies are congruent with the tenets of service

learning and community-based research, which blur the roles of patient and practitioner (Reynolds, 2005). The characteristics of the researcher–participant relationship in feminist methodologies therefore serve the purpose of this study most appropriately. My interviews and interpersonal interactions were characterized by openness, sharing, and mutual reflection. Although the full extent of future friendships with respondents as posited by Bloom (1998) was unclear at the beginning of the research, during and after the conclusion of the research, I have continued to interact with each participant with openness and acceptance, and even a level of friendship when we see each other at the clinic. I treasure and appreciate the role each participant–patient contributed as both a teacher and collaborator in the co-creation of this research and contribution to pedagogical knowledge in health care education.

Applied Ethnography

By definition, ethnography is an in-depth study of a social phenomenon or entity, its culture, and a way of organizing fulfillment of social roles, whether stated or unstated (Creswell, 1998). Ethnography most often relies on the researcher in various roles of participant and observer, perhaps even as an insider (McMillan & Schumacher, 1997). By virtue of the insider vantage point, new and deeper understandings of the layers of meaning and complexity of the participant lives are revealed relative to the institution or focus of study. The trust and rapport gained by the researcher as participant–observer may give way to spontaneous, candid, and unguarded exchanges that otherwise would not be captured in the data collection if other methodologies were employed (Bishop, 2005).

In the fall of 2004, I began developing relationships with the Free Clinics of Iowa (FCI) executive director and clinic managers. During 2005, FCI network member clinics participated in a study to assess the feasibility of adding medical specialty services (i.e.,

physical therapy and podiatry) to existing primary care services, as well as initiating a service learning program with a local health professions school (Duffy & Mahoney, 2005).

Gradually my relationship and role with FCI has moved along the continuum of observer in 2004 to a place as a relative insider as a volunteer in 2006. FCI was the cooperating institution for this research in 2006. In January 2006, the Institutional Review Board (IRB) at Iowa State University granted approval for this research.

This study can appropriately be considered “applied ethnographic research” because of the emphasis on curriculum application and the application of findings to the policies of the free clinic network. Chambers (2003) described characteristics of applied ethnography. For myself, this dissertation is applied ethnography for the following characteristics and reasons: (a) because of how it was conducted through participant–observation, (b) because of my engagement in the mission and advocacy of the participants and the organization for which they are engaged, and (c) because of how the results themselves emerged through semistructured interviews and open coding of data (Chambers). Applied ethnography is important for the applied outcomes that enhance the knowledge of a given social concern, as well as the applied solutions to real life (Chambers). The greatest social concern for the community is facilitating access to quality health care to the underserved. The applied solutions from this research include a change in the pedagogy of cultural competence training of health professionals as well as the faculty who are the critical role models for these future caregivers.

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CHAPTER 2
HOLES IN THE HEALTH CARE SAFETY NET:
VOICES OF THE UNDERSERVED

A paper published in the *Journal of Physical Therapy Education*

Pamela A. Duffy

Abstract

Physical therapy programs seek community-based learning experiences for students. The purpose of this ethnographic study is to develop an understanding of the experiences of individuals seeking health care at community-based free medical clinics. The free clinic in this study is located in a suburban neighborhood community center in the Midwest. Three women and 3 men were purposively selected for participation based on recommendations from the clinic manager. Participants were involved in 2 in-depth interviews and follow-up meetings over a 6-month period. Extensive observations supplemented interview data. Feminist methodologies were used to analyze the data and develop the themes. The patients/clients value the caring behaviors and respect shown to them by clinic volunteers. They reported seeking health care at free medical clinics because they are unable to meet out-of-pocket costs associated with physician-office visits and over-the-counter (OTC) medications, as well as lack of coverage for preventive services. Patients/clients with limited financial resources state they are more likely to feel stigmatized in traditional health care settings than at free medical clinics. Patients/clients seeking services at free medical clinics need to be viewed by health care practitioners and volunteers beyond demographics and medical conditions. Patients/clients are immersed in complex life circumstances that create the context for health care interventions. Patient-centered care means creating space for

dialogue beyond the chief complaint, even though all needed services cannot be provided in the free clinic setting.

Introduction and Background

Other than hospital emergency rooms, 2 forms of ambulatory health care settings exist to provide health care services for the underserved. Community-based medical clinics typically take the form of either federally qualified community health centers (FQHC) operated through grant funding, or a free medical clinic that springs up through the efforts of local civic or religious groups.² FQHCs must be established in medically underserved areas (MUA) or serve a medically underserved population (MUP), meet extensive administrative reporting requirements, and provide specified primary care services in order to receive federal funding.¹ In addition, they must also provide supportive services like transportation, interpretive services, social services, and patient/client education. There is great variation in the look and feel of free clinics around the country, in part because of their inception in the community through volunteer initiatives.

Free clinics are typically supported through donations, volunteer professionals and staff, in-kind gifts, and rent-free locations in churches and community centers. The focus and mission of most free clinics is to provide urgent and preventive care services. Few free clinics are adequately staffed or set up for specialty care, mental health services, or dental care. Free clinics supplement services provided by FQHCs and emergency rooms. However, FQHCs cannot meet the need for health care that exists in the poorest counties in the US. Without free clinics, the outlook for the underserved would be even direr.

Whether faith-based or secular, the free medical clinics have often been referred to as the last resort for individuals and families in poverty struggling with financial and social

stresses that required urgent health care. However, public perception may not be keeping up with the changing profile of patients/clients actually receiving health care in free clinics. With rising health insurance premiums and larger proportions of out-of-pocket expenses passed on to employees, more and more working families and individuals are seeking health care in free clinics rather than physician and practitioner offices, even when they have insurance.

Literature on free clinics is often descriptive in nature, outlining demographics of the patients/clients and the categories of health care services provided. But this type of reporting provides just a small window into the large unmet need for medical, dental, and mental health services in the US.^{2,4} In this article, I will explore the complexities of patient/client lives behind the statistics and demographic reporting. The purpose of this article is to provide health care professionals and academic faculty with a greater understanding of the patients'/clients' views of the patient–professional relationship and delivery of health care in the free clinic setting. Because physical therapy programs are increasingly seeking community-based clinics for service-learning and venues for experiential learning,⁵ it is essential that physical therapy educators understand the layers of meaning connected to these encounters from the patients'/clients' perspective.

Methodology and Methods

Ethnography is the study of a group (organization, institution, or population) through observation and interaction with the members of the group.⁶ Rooted in anthropology and sociology, ethnography is a form of qualitative inquiry in which the relationships of the participants, the cultural norms of a group, and the basis for their interactions with internal and external parties are central concerns.^{6,7} I chose ethnographic research for this study

because of the importance of understanding patient, staff, and volunteer experiences in the context of community-based health care. In this article, I will report the patient's/client's perspective, which is supplemented by my own field notes and observations as a free-clinic volunteer. I selected feminist methodologies as critical to the research design and methods, as well as indispensable to the analysis of the intersection of gender, race, ethnicity, sexuality, ability, disability, and socioeconomic status of the participants.⁸⁻¹²

The Research Site: The Free Clinic

I conducted this study at a free medical clinic in a suburb of a large Midwestern city with a poverty rate of 4.5%.¹³ The percentage of people living in poverty in this suburb is less than the county percentage of 8.6%, and the state level of 9.1%.¹³ The racial make-up of this suburb are as follows: 92.7% white; 1.9% African American/black; 2.8% Asian or Hispanic/Latino; 3.1% American Indian/Alaskan Native; and 2.6% reporting other or 2 or more races.¹³ The free clinic in this study is 1 of 19 independent free clinics associated with a volunteer network organized to provide administrative support and not-for-profit status for member clinics. The clinic was selected among the network clinics because of the receptiveness of the clinic manager and its organizational structure.

Participants

I recruited adult patients/clients for participation largely upon the recommendation of the clinic manager based on his expectation that the patients/clients would be interested in the study and meet the study criteria. Six respondents were selected as a reasonable number to gain understanding into the patient perspective, and as a realistic number of likely participants who would be able to agree to return for private interviews. The participants met with the researcher for at least 2 in-depth interviews at the community center and at least 1

member check to allow the participants to review the research results, clarify direct quotes, and supplement the initial interview data with other responses after time for reflection on the interview experience. Participants were assigned pseudonyms for recording and reporting results.

Ryan is a mild-mannered, 22-year-old white man, recently unemployed, and temporarily living with his parents in a small rural town more than 30 miles from the clinic. He is back in the town where he grew up and went to high school, finding construction work as he can, and relying on his parents for transportation while his driver's license is suspended. When Ryan was a trade union member, he had good health insurance benefits; but is he no longer in the union nor eligible for coverage under his parents' health insurance, and cannot afford an individual health insurance policy. Ryan's mother suggested he come to the free clinic for an acute illness since he did not have insurance. She heard about the free clinic from a co-worker, Neesie, who is also a participant in the study.

Shelby is an outgoing 53-year-old white woman who regularly seeks care at the free clinic for chronic health conditions and can access the clinic's sample medications and receive prescriptions for maintenance medications. Although Shelby has private medical insurance for potential high-dollar health care services or hospitalizations, her annual income is less than \$15,000, and out-of-pocket costs for prescription medications take a large portion of her monthly income. The co-payments for physician office visits and prescription medication, as well as the time needed away from work to seek health care during typical office hours, represent significant barriers to managing her chronic physical diseases and mental illness. The free clinic is a few blocks from her home and she knows many of the people from the community who volunteer there or come on Tuesdays for the evening meal.

Shelby recently started a bookkeeping job at a local hospital, but has found the work-environment anxiety provoking and stressful. During the study, Shelby lost her job, and found herself unemployed.

Mr. Ortiz is a 65-year-old Hispanic man, living with his daughter, her husband, and their 6 children and foster children in a suburban area 10 miles from the clinic. His daughter describes him as “homeless” because he has no residence of his own and stays with various children for periods throughout the year. He is eligible for Medicare, but does not know how to access these benefits. He has many chronic medical conditions and is dependent upon his daughter for transportation to and from the clinic. Mr. Ortiz and several family members will often come to the clinic on a Tuesday for the evening meal, followed by visiting the doctor for examinations and free medications or assistance in signing up for the various pharmacy benefit programs for those eligible.

Michelle is a 52-year-old white woman who began attending the free clinic over 10 years ago, and has continued because visits to regular doctors’ offices exacerbate her anxiety disorder. Her husband is approximately 15 years older than she and a long-distance truck driver. For the last couple of years she has been the primary caregiver for her granddaughter, due to her son’s and daughter-in-law’s difficulties with drug abuse and subsequent arrests that have resulted in felony convictions and imprisonment. Michelle has written local newspaper editorials about prison rape and needed care for prisoners. She maintains health insurance through the Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits (enacted in 1986) for medical conditions that cannot be treated at the free clinic.

Michelle’s brother, Bob, is a 44-year-old homeless man who lives in his station wagon at a rest stop approximately 20 miles from the clinic. Michelle referred him to the

clinic when he became unemployed and needed medical attention for hypertension and other health conditions. Bill has been employed on-and-off over the last 10 years and is trying to get his driver's license back. Bill was working until last year, when he hurt his back lifting dishes at the restaurant where he was a busboy and kitchen worker. He has not obtained any formal education or certifications, even though when he was younger he attended a few training programs. Lack of financial support caused him to drop out. Although he has managed a local fast-food restaurant and other manual labor jobs, he is now looking for a job that will not pose a risk to his back condition. He has 2 daughters living out-of-state, and is behind in his child support, but hopes to see them when he catches up with that obligation.

Neesie is a 53-year-old black woman who is married to the community center's pastor. Like her in-laws, husband, and other relatives, she is involved in the community center's weekly activities. Her extended family is the mainstay of the community center. Neesie and her current husband have custody 3 of her daughters, ages 11, 9, and 4. When Neesie divorced 12 years ago, her oldest daughter struggled emotionally, becoming pregnant with her first child at age 14. Over the last 10 years, Neesie's daughter has been in and out of prison, and has given birth to 2 more children. Neesie has provided all the day-to-day childrearing, love, and care for all 3 of her grandchildren. If they are sick, getting them to the doctor's office means missing work and taking the kids out of day care and school. She brings the grandchildren to the free clinic for various childhood illnesses and immunizations on Tuesday evenings after the weekly meal. Neesie and her husband have health insurance through her full-time employment at an insurance company, and the children have health-insurance coverage under the state Medicaid program.

Data Collection

Semi-structured, in-depth interviews and participant observation were techniques used for data collection over a 5-month period. These data were augmented with staff interviews and weekly field notes made during my weekly volunteer activities as a participant observer.

Findings and Discussion

Free Clinic Environment

It is a friendly atmosphere at the community center. One of the clinic's patients/clients, Shelby, enthusiastically reports, "It's like family here." Ryan agrees and says, "Being in the community center is great. Everyone talks to each other and that is nice. They are all very concerned about each other." Neesie emphasizes that the free clinic is an integral part of the core services extended by the community center to help meet the physical needs of individuals in the area. "We want everyone to feel welcome at the community center. It doesn't matter why they come. It truly is like a family here. . . ."

Shelby goes on to explain that the contact with people at the community center and free clinic volunteers is more than mere friendliness. She describes it this way: "I feel like they care about you here, and they do everything they can to help you, no matter who you are or why you are there." Ryan admits that, although he tries to avoid doctors and dentists, "Coming to the free clinic was not difficult. I'd come back again." In fact, he says, "Not only did the doctors take care of my problem quickly, they were all really nice and talked to me like a normal person, not all sophisticated and professional, just normal." The patients/clients emphasized that the interactions with volunteers at the free clinic was one of the most

significant differences in how they experienced health care compared to other health care environments like offices, emergency rooms, and hospitals.

For the patients/clients, this key variable is the communication of acceptance. Michelle describes the patient/client and staff exchanges this way: “They treat me like a human being, like a person. They treat you just like you’re a regular person that was in a regular doctor’s office. Actually, I think they treat you better than in a regular doctor’s office, truthfully.” The patients/clients believe that some of the harsh treatment and lack of acceptance at regular doctor’s offices is directly related to their financial circumstances.

Michelle has private health insurance to protect against the high-cost of hospitalizations or severe illness which cannot be treated at the free clinic. Michelle goes to the free clinic even though she has health insurance because of what she calls “dehumanizing treatment at doctors’ offices.” The disrespect she reports includes inordinate waiting to see the physician, failure of the provider and staff to answer her questions about her health condition, derisive nonverbal communication, and failure to initiate follow-up appointments when obviously needed. At times, health care workers have made comments implying that she does not maintain good hygiene or is not diligent about managing her chronic conditions. She found those remarks to be both insulting and a reflection of personal biases.

Patients/clients denied any stigma or embarrassment associated with going to the free clinics. However, sometimes patients/clients do not admit to others that they attend the free clinic. Shelby is careful about sharing the fact that she attends the free clinic because others have criticized her for doing so when she has health insurance. She says, “I basically am embarrassed because most people think if you have a job at all, or any money at all, that there are people worse off than you, so I might be taking up the space that [sic] somebody who is

worse off than I am could be using.” Critics of Shelby’s using a free clinic maintain that “As long as you can afford to pay or you have a job and income, you shouldn’t be going there to the free clinic. If they’re seeing you, then they can’t be seeing somebody that doesn’t have an income at all in place of you.”

All of the participants in the study stated that they believe most people, including health care workers, do not understand the importance of free-medical clinics, and why people are seeking their services. The fact is that being homeless, uninsured, or underinsured affects greater segments of the US population than people realize.^{2,14-18} Shelby says that the co-pays and cost of medication makes going to her regular doctor unaffordable even when she is working at \$9/hour jobs. Shelby is among the growing number of working poor for whom free clinics provide the safety net to keep them from losing any or all assets because of health-related expenses and complications of chronic illness and comorbidities.^{2,18-20}

Limitations of Free Clinics: “What Hurts the Worst?”

As welcoming and accepting as the free clinic’s volunteer health professionals and staff are to all patients/clients, safety net providers deal with real constraints that impact the delivery of health care and the relationships between the health care providers and the patients/clients. In explicit ways and curricula, the regular health care system and professional training teaches doctors, nurses, and other practitioners to focus on a chief complaint. But, for vulnerable populations, it boils down to “what hurts the worst,” as Shelby says. Shelby elaborates on this by saying, “Because you can live with the other stuff, but what hurts the worst is what you can’t stand anymore and why you come to the clinic. The other stuff you deal with—it is always there. It would be nice for the doctors to know more about me and my life, but why? They are only here 1 time a month, and I may never see them

again.” Patients recognize that getting the doctor at the free clinic to understand all of their medical conditions may not be possible, so they may choose to be selective when reporting their medical history.

Unfortunately, many safety net providers are not established or equipped to be the patient’s/client’s primary care physician or medical home. The explicit mission of this free clinic is that of stop-gap provider. Even though patients/clients find the free clinic atmosphere preferable to their previous experiences in traditional health care offices, there are obvious and numerous limitations when patients/clients only seek care at a free clinic.

The Context of Patients Lives: “You’re Always Living a Double Life”

Patients/clients rarely have the space to be really honest about all the circumstances that compound “what hurts the most.” There is also some concern about feeling vulnerable on another level and sharing deep and personal feelings and then not having them treasured, valued, or reciprocated. Shelby says, “First of all, if the doctors really wanted to know, they would ask about the medications I take, like Lexapro—it’s all written down in my record. They know what those drugs are for. But they don’t ask. So things stay pretty superficial for the most part.” When pressed on this subject, Shelby admitted that most patients/clients are living a double life and “. . . don’t want to get into everything about themselves. Everybody that comes here, and myself, we live a double life all the time. They may be embarrassed or self-conscious about not having a job or not having insurance, and afraid of what people think.”

Michelle talks about the patient/client–professional relationship at the free clinic as one where respect means that providers understand that “people are more than their illness or how they look at the moment. The people at the free clinic understand that they are only

seeing a very small piece of their patient's/client's life." During our interviews, Michelle talked about the difficulties of raising her 3-year-old granddaughter while suffering from depression, which robs her of any and all energy. She has wanted to do more with her life but says that depression and anxiety make it difficult to pick up the clutter in her house, let alone strive for anything else. In fact, she has an eye for antiques and says, "I thought I might open a little shop someday. That was before my mother and sister died and my son went to prison. I had dreams once," she said, with tears in her eyes, "but some of those left me when my father was beating me, and with how my life has turned out."

Patients as Their Own Advocates: "Watching Out for Myself"

The patients interviewed for this study possess a relatively sophisticated knowledge base about their health and their bodies, and it is evident in how they advocate for themselves and their families. In general, all participants said this was especially important in the absence of a primary care doctor to coordinate the services they receive at the free clinic with specialty services, prescription medication, and visits to other practitioners. "I always have to be watching out for myself," Ryan says when asked about who keeps track of his health conditions. When I asked Bob how he knew all the medical terminology related to some unique and rare medical procedures he has had in his lifetime, he replied, "I read a lot. I have to be able to tell the doctors what I've had before and what they need to do to take care of my current problems. They don't know." The patients/clients cannot rely on a medical home or family physician to coordinate multiple health conditions or schedule preventative care, so they do it.

Neesie had a doctor in her family physician's office scold her for taking her grandchildren to the free clinic for an ear infection. She was angry and astonished at the same

time. She called me specifically to report that having the free clinic in the community center means convenience. Convenience translates to financial resource implications as well as managing the complexities of family life. Taking her grandchildren to the free clinic at the first sign of illness means that she does not have to leave work to take the children to the doctor. The clinic is open in the evening and most doctor offices are not. Her paid time off is not unlimited, and it is difficult to take children out of school in the middle of the day. In addition, there is typically a wait to get an appointment to see the regular physician, which results in the children getting sicker and missing school, and suffering longer with an illness that has progressed to a greater level of severity. “Why would I put my grandchildren through that pain when I don’t have to?” she asks rhetorically.

Intersection of Housing and Health: “I Need a Place Where I Can Be”

All of the men in the study were without permanent housing. This was not known or apparent to the clinic staff or manager when they were referred for the study. Even so, staff members are often asked for help in accessing housing and social programs. For patients/clients who do not speak English as a primary language, or who are new to the geographic area because of foreign immigration, barriers to accessing community support services are greatly magnified and the process is fraught with uncertainty. As a volunteer staff member, the role of the physical therapist at the free clinic goes well beyond traditional physical therapy interventions and encompasses assistance in coordinating care as well as supporting patients/clients in their efforts to function more effectively within the community.²¹ In one instance I was able to support Mr. Ortiz’s application for affordable housing by writing to appropriate authorities about the functional limitations of his medical conditions. “I don’t want to be a burden on my children, and I need a place where I can be.”

Mr. Ortiz says that he is grateful to live with his daughter, but at the same time is under stress from living with 8 children in 1 household. This affects his ability to get adequate sleep and take care of his heart condition.

Bob goes to the free clinic for chronic illnesses like his hypertension. He is unemployed, sleeps at night in the station wagon his sister bought for him, and visits her home in the daytime when she will have him. His nutrition is inadequate and he does not have regular access to needed prescription coverage. At times, the clinic manager was afraid that Bob might have a stroke because his blood pressure was uncontrolled and extremely high. Typically, the clinic is not able to provide financing for prescriptions or other medical needs, but in this case, it was an emergency situation; Bob was given a check to give the pharmacy for his medication.

Summary

The findings in this study have implications for clinicians and particularly for educators who are preparing future health care professionals. Students and faculty need to understand both the changes in health care insurance associated with employer-based models of coverage, as well as the impact this has on how patients/clients access health care. Whether patients/clients are accessing office or safety net providers, the themes arising from this research are informative to the patient/client–professional relationship. The major themes identified in the study are as follows:

1. As employers increasingly shift the burden of rising health care costs to employees, resulting in higher out-of-pocket expenses, individuals will either avoid obtaining preventive or regular medical care in a timely manner, or will seek community-based health care found at free clinics.

2. Cultural sensitivity and being present for the patient/client in the available time is the most important aspect of the patient/client–professional relationship. Participants all reported that they were treated with respect and care by the free clinic volunteers.²¹ Interestingly, this occurred even in the absence of detailed inventories of cultural attributes or explorations of cultural domains and characteristics, as is advocated in the literature.^{22,23}

3. Individuals without insurance or financial resources are subjected to dehumanizing treatment in most environments thought of as “regular” health care. Disguised as administrative processes, invasive probing into personal financial information and sources of payment creates embarrassment and is intimidating to patients/clients.²⁴ For patients/clients who qualify for Medicaid or other assistance programs, health care professionals and office staff frequently convey unwelcoming, hostile attitudes that discourage patients/clients from seeking needed services.

4. If the physician or health care provider is unable to take time to learn about the patient’s/client’s life through their own words, the provider will not understand the chief complaint within the context of that patient’s/client’s life. Consequently, the patient/client may not receive the most appropriate and effective intervention or recommendations. In many ways, this interaction allows the patient/client to serve as teacher to professionals and students. Failure to be compliant, for example, does not simply reflect a lack of knowledge or motivation, but may actually be the result of balancing the demands of multiple family and social roles, financial constraints, complex mental and emotional issues, and limitations in transportation and child care.

Important, ubiquitous, secondary themes arose in this study concerning the standpoint of patients/clients. These secondary themes included the resiliency, resourcefulness, and

agency demonstrated and expressed by each patient/client as they spoke about their circumstances, both past and present. These themes are also supported in the literature.²⁵⁻²⁸

As Bob stated, “Where you’re [sic] going to live? How you’re [sic] going to pay for anything without a job, [or] any money. It could be pretty stressful if you let it get to you, but, you know I figure things will get better. I always have a positive outlook. I realize that if you don’t believe they’re going to get better, then why bother? So, it’s just a bump in the road. Just another wrong turn. I’ll get back on the right path either sooner or later.”

Conclusions and Relevance to Practice

Many health care education programs include service learning or community outreach with underserved populations in their curricula to better prepare their graduates to effectively treat patients/clients whose health care needs are both medically and socially complex.²⁹

Service learning programs are one way that academic programs successfully integrate reflection and affective domain skills into curricula. Providing the opportunity for physical therapy students to interact with patients/clients within the context of their family and environment helps the students experience an important tenet of reciprocity in service-learning, appreciating the “patient as teacher.”³⁰

The benefits to students in health care professions is documented in the literature, but the reciprocal nature of the relationship between the providers at free clinics and the patients/clients is less well known.^{21,29,31} This study explored the meaning of health care services at a free clinic from the patient/client perspective. Data revealed that illness, wellness, and the health care experience cannot be separated from the context of individuals’ lived experience.

What meaning and implications do the results of this study have for defining patient/client-centered care and the role of the patient/client as teacher in community-based or pro bono clinics? The community center context reinforced the message of caring and interest in patients/clients as unique individuals and created another circle of support around them. For many patients/clients in this study who used these free clinic services on a recurrent basis, the relationships with the community center volunteers and other attendees, as well as the clinic volunteers and staff, form the strongest portion of their support system.

Patients/clients who seek services in free clinics are an increasingly diverse population that includes individuals with health insurance, those who are employed, and those who also receive care in what participants call “regular” settings. The face of the homeless and uninsured has changed dramatically in the last 5 years. Stereotypical depictions of the physical appearance and behavioral characteristics of vulnerable populations should never be used as the basis of understanding the complexities of patient/client lives, nor the multiple subjectivities of patients/clients seeking care.⁸

Patients/clients want health care professionals to create an atmosphere that allows them to share sensitive, personal information and know that it is respected, not to merely keep it confidential. Consistent with Levi and Walens’ findings, cultural sensitivity rather than cultural knowledge per se is the most critical element of the patient/client–professional interaction.^{21,32,33}

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CHAPTER 3.
**HOLES IN THE HEALTH CARE SAFETY NET:
THE FREE CLINIC VOLUNTEER PERSPECTIVE**

A paper prepared for submission to the
Journal of Health Care for the Poor and Underserved

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Abstract

Free clinics operate largely on donated supplies, clinic space, and volunteer help. The purpose of this article is to provide insight into the volunteer perspective about the services they provide at free clinics. Feminist methodologies and methods consistent with qualitative inquiry were used for data collection and analysis. Participants were purposively selected to participate in one in-depth interview and one focus group. These data were supplemented with extensive observations and field notes. Conclusions: The traditional role of free clinics to improve access to medical services is changing from a focus on acute primary care for the indigent and homeless to providing health care for the working poor and individuals with chronic conditions. Huge unmet need for health care and pharmaceuticals for the increasing population of uninsured Americans cannot be met by free clinics alone. Free clinic volunteers do what they can to meet basic needs but recognize that their work does not address gaps in specialty care services like dental care, obstetrical and gynecologic services, and mental health treatment. Uninsured patients are seeking continuing care at the free clinic and using it as if it were their medical home and a source of prescription drugs to manage acute and chronic conditions. Volunteers report various motivations for their ongoing volunteer services. The volunteers find their experiences to be a fulfillment of their desire to give back to their community, a way to meet an obligation of professional duty, and hold to

the moral belief that they should help those in need. When possible the volunteers try to connect the patients to other community services and pharmacy assistance programs.

Introduction

With more than 45 million uninsured Americans, the public discourse on health care accessibility has become more persistent.¹ The mounting debate, in part, is recognition of the enormity of this growing societal quandary. It is also true that more and more individuals and families from the mainstream of society are uninsured or underinsured. For this reason, I believe that the topic of the uninsured has taken on a heightened prominence because “average” Americans are affected at greater frequency than a decade ago. Most people understand that their own chances of becoming uninsured are far greater than they were even five years ago.

The health insurance crisis is not just about the uninsured, but also about the underinsured. While simultaneously experiencing increasing restrictions and constraints on covered services, employees also bear a significant portion of the rising cost of insurance for self and dependents through higher deductibles. The financial barriers to health care may force individuals and families to neglect important routine health care to the point that minor medical conditions worsen, consequently requiring more substantial health care intervention. Ultimately, this results in poorer health status. It also means that the uninsured and underinsured seek places to receive free or affordable health care. Until the U.S. fundamentally addresses affordability and accessibility issues, there will be a greater burden on the safety net providers who give free or low-cost health care.

No one remains untouched by the entrenched, employer-based health insurance paradigm. The ability to obtain affordable health insurance is the key to accessing health care

services on a regular basis and to establishing a beneficial relationship with health care providers who know and understand them.² Essentially, having health insurance equates to health and wellness. Being insured is associated with accessibility to health care services for acute illness as well as chronic disease management. The uninsured and underinsured face a system fraught with sometimes insurmountable economic barriers to access the health care system or stigma when relying on government programs for assistance. Nonetheless, the rising cost of health care services begs the question, “How long can this system of corporate health insurance sponsorship endure?” Secondly, should it?

Within the health insurance industry, recent notable changes are influencing affordability of health insurance for workers. Double digit increases in insurance premiums over the past five years have motivated employers, together with insurers, to develop business strategies to reduce the employer cost of health care. Employees feel the brunt of these changes as increases in cost-sharing of health insurance premiums. Cost-sharing can be defined as the amount of out-of-pocket expenses workers pay for both the insurance premium itself and the medical services. For example, employers, who in the past, may have paid 80 to 90% of insurance premiums for workers, now require employees to contribute a larger or equal proportion of premiums in the form of co-insurance and co-payments. Employee costs for dependent coverage and annual deductible amounts are also steadily rising. Lastly, some businesses simply decide to eliminate health insurance benefits altogether to stave off the drain to the company bottom line. For the working poor and middle class, these employer-directed tactics to reduce health care costs drive up the ranks of the uninsured.³

As more scrutiny is focused on the plight of the uninsured, a distinct new category of uninsured has emerged. For now, the fastest growing segment of uninsured Americans are

ages 18 to 30.⁴ This group of young adults many no longer be covered under their parent's health insurance. Typically they are not eligible for some state and federal programs targeted toward children or the elderly.^a Even if employed, younger workers may not consider health insurance coverage as a priority when faced with the employee share of health insurance premiums. They may not see value in employer-sponsored health insurance when considered in the context of fixed housing and transportation expenses, student loan debt, and other priorities. Especially when young adults perceive themselves as essentially healthy and at little risk of disease or injury, there is the perception that obtaining health insurance can wait.⁵

As a result, this younger, mostly healthier cohort is less likely to receive preventive care, education about maintaining optimum health, and interventions to prevent chronic disease. They do not establish relationships with primary care physicians and typically avoid traditional health care services altogether. For those who are cognizant of the existence of safety net providers, they look to free clinics for health care services when the need arises. Colds, flu, and minor health problems may not require professional health care services, but if they do, going to a free clinic may be the substitute for trying to get an appointment with a physician that they do not know or that cannot see them for two weeks. For more severe and unmanaged acute and chronic conditions, these younger patients end up at the doorstep of the emergency room. Even though these services are more expensive, the calculation that could be made by this demographic is that occasional out-of-pocket costs for emergency care will be less expensive than annual deductibles, monthly insurance premiums, and other out-of-

^a Examples of state and federal programs in include the State Children's Health Insurance Plan (SCHIP), Medicaid, and Medicare

pocket expenses. Free clinics provide services that may not even be covered under most health insurance plans like daycare, school and college physicals, sports participation examinations, pre-employment physicals, and immunizations.

Operating Under the Radar. Seemingly unapparent to policymakers is the significant combined economic and societal contribution that organizations comprising the health care safety net make to their communities at large. The safety net provider category includes organizations and agencies such as Federally Qualified Health Centers, community health centers, public hospitals, and free medical clinics. For the uninsured and underserved in our current health care system, free medical clinics may actually represent some of the most accessible health care in the U.S., as well as the most underrepresented in calculations. However, free clinics in general prefer to “fly under the radar screen” of government and regulatory oversight for several reasons. In his seminal work on free clinics, Weiss⁶ described the history and culture of the free clinic movement, which lays out the context of how free clinics have evolved.

Free clinics in the U.S. began during the height of the social revolution of the 1960s and 1970s. Primarily dedicated to the health care needs of young people involved in anti-establishment lifestyles, these free medical clinics operated independently and without government support.⁶⁻⁸ Attempts to organize nationally were ultimately unsuccessful because of the inherent mistrust of centralized bureaucracy, any government or other granteeship, and the need for each clinic to address local issues.⁶ Primarily a West Coast phenomenon in the 1960s and 1970s, free clinics spread throughout the country in the 1980s and 1990s, focusing their work on the needs of the homeless and indigent populations, disconnected from mainstream medicine and living on the margins of society.

Most free clinics prefer the autonomy and efficiency of operating without government oversight and regulation. More recently, free clinics largely exist to serve the large number of the underinsured and currently are seeing a greater segment of the population referred to as the working poor.⁹ Free clinics are becoming more integrated into the traditional medical system and, in some regions, organizing around networks or consortiums.⁶ There is no doubt that these services are drastically needed for both acute and chronic disease, for young and old alike, and for a growing number of individuals and families who comprise the ranks of those making too much income to qualify for federal programs as well as some middle class Americans. Some clinics secure financial support single-handedly whereas others find networks or larger organizations desirable or necessary to provide essential services and operate more efficiently.

The Free Clinics of Iowa. This study was conducted at a member clinic of the Free Clinics of Iowa, a network of approximately 20 independent free clinics throughout Iowa.^{b,c} In general, free clinics operate on dramatically fewer resources than most physician offices but, nonetheless, still require sources of capital to purchase supplies or for other operational expenses. Even though the free clinic is viewed as a provider of last resort for the uninsured there are a small percentage of patients who have Medicare, Medicaid or some other third party insurance. However, the free clinic in this study, as with most, does not bill third parties through either private or public health insurance programs. The patients with government sponsored health care, Medicare and Medicaid programs, typically come to the free clinic

^b The Free Clinics of Iowa is a 501.C.3 tax exempt organization with the stated mission is “To facilitate the initiation, operation and collaboration of free medical clinics in the State of Iowa (2006 Annual Report).

^c I have been a member of the Free Clinics of Iowa Board of Directors since July, 2006.

because they either cannot take time off work or cannot afford out-of-pocket expenses associated with deductibles, co-payments, prescription drugs, and other non-covered services.¹⁰ The question might reasonably be asked as to why individuals eligible for state or federal programs are not enrolled at the free clinic. The simple answer is lack of trained staff and capacity to implement this administrative service.

The free clinic does receive financial support and in-kind contributions to provide health care services from a variety of sources. In-kind contributions include donated prescription drug samples from physician offices or pharmaceutical companies as well as volunteer professional services of doctors, nurses, and other health care providers. In the past two years, the clinic has received some annual funds from a state government appropriation to the network. Additional funding is typically sought from local service groups, with a very small portion of annual funds coming from freewill donations from patients.

Besides the annual disbursement from the state appropriation, the clinic also receives tangible operational support from the network. The network provides professional and business liability insurance, accounting and tax-filing services, computer hardware and software, as well as modest funding for office supplies, medical supplies, and pharmaceuticals. The not-for-profit status of the network is also critical to successfully securing in-kind and cash donations to the local clinic. Altogether the network provides untold value to the clinic so they can provide free health care to those who seek it, “no questions asked.”¹⁰

The free clinic does not engage in formal marketing and promotional activities, yet there is rarely a night that the clinic is not busy. The community center where the free clinic is located is situated in a relatively affluent suburb with approximately half the rate of

poverty of the entire state average.¹¹ The suburb's poverty rate is only 4.5% compared to the county at 8.8% and the state at 9.1% (see Table 1). Apart from direct referrals from the city department of social services agency, local school nurses, and a few small, local employers, word-of-mouth advertising is responsible for the steady stream of new patients seeking care. Patients refer family members and friends, neighbors, and co-workers. The community center itself is the other fundamental connection between clinic services and patients.

The vital linkage between the medical clinic and the community center exists on several levels. The mission of the community center is to afford nourishment for the body, mind, and soul for all who come. On Tuesday evenings during the school year, volunteers from local churches serve hot meals before the free clinic opens. The same room is used for the church services on Wednesday evening and Sunday morning. On a concrete level, the free clinic provides treatment for illness and disease, healing the body by caring for physical needs, while the community center nourishes the soul through Christian service work supporting the needs of individuals and families needs with food, shelter, and clothing, as well as respite, socialization, companionship, and more.

In a reciprocal fashion, the community center and the free clinic recommend each organization to their clients. The free clinic refers patients to the community center for vocational and avocational activities, services, and programs. These might include the community meals, the free "Food Pantry" and "Clothes Closet," legal assistance, fellowship and church services, and computer classes. The free clinic is really the backbone of the community center according to the clinic manager. However, it is the synergistic relationship of the free clinic and the community center that represents demonstrated growing social support, social capital, and community capacity for this suburb.¹²

Social capital,^{13,14} defined as the ability of individuals to contribute to the greater community, is evidenced in the free clinic's health services that promote health and wellness, prevent illness, and promote optimism and trust. The clinic offers care for acute and chronic illness, employment physicals for adults and teenagers, school and sports physicals for children and youth of all ages, and pre-school physicals, including immunizations, for infants and young children. Community center leaders showcase the clinic by giving tours and telling the clinic story to civic leaders, volunteers, and civic organizations. As a result of the community center's low-key promotion to community partners, the free clinic derives monetary contributions from local area fundraisers to support the delivery of health care to patients. The community center also makes direct financial contributions for direct patient services several times a year.

The clinic operates like a regular doctor's office with the notable exception that the registration process is relatively simple and streamlined compared to other medical offices. The underlying assumption of the Free Clinics of Iowa staff and all free clinic volunteers is that if someone is coming to a free clinic, they don't have other options. Each free clinic collects demographic information on a one-page intake form to better understand services that are needed and gain information about patient backgrounds and characteristics in the aggregate. The Free Clinics of Iowa staff provides this cumulative data for all the member clinics to funding groups, state legislative committees, and community sponsors.

Critical to understanding the role of free clinics is the analysis of the intersectionality of gender, race, and class of the patients who seek services.¹⁵⁻¹⁸ The gendered nature of poverty in the U.S. and the impact of being uninsured¹⁹ is also reflected in the data reported from this free clinic. Most patients seeking health care are female, and typically women, as is

found in all other health care settings, are responsible for the family. More than half of all patients at the free clinic are female (see Table 2) and seek health care for themselves, their children, and other relatives. Approximately one third of all patients seen at the free clinic are infants, children, or adolescents under the age of 18 (see Table 3). Mothers, grandmothers, aunts, neighbors, and other women connected to the family bring children for well-baby care, immunizations, and physicals. However, the free clinic does not provide health care services for obstetrical and gynecology services for any number of reasons. For example, many of the volunteer physicians do not practice in this specialty or in primary care and are not comfortable performing these services; the clinic is not equipped to be a source of regular follow-up care for pregnancy and other concomitant services.

On the registration form patients are asked if they have insurance and, if so, what type (i.e., none, Medicare, Medicaid, private insurance, or other). Patients most often report their insurance status as uninsured (see Table 4). Nearly 70% of the patients seeking care at the free clinic do not have health insurance. Approximately 60% of all patients are between the ages of 18 and 64 (see Table 3), too old to qualify for SCHIPs and too young to receive Medicare benefits. They are caught in a very real hole in the health care safety net. Even patients with some type of insurance need assistance with the cost of prescription drugs and basic health care services that are not covered in by the health insurance plan in which they are enrolled. Over 50% of patients report cost as the primary reason that they come to the free clinic rather than a regular clinic (see Table 5).

Racial and ethnic minorities are more greatly impacted by lack of access to health care because of lack of health insurance. Conversely, being insured ultimately mitigates health outcome disparity among racial and ethnic minorities as compared to Whites.²⁰ The

free clinic offers accessibility to health care services which would otherwise be unaffordable and unattainable for the uninsured. Of interest is the disproportionate number of patients of racial and ethnic minorities compared to the population as a whole for this city (see Table 3). Black or African represent approximately 12% and Hispanics approximately 25%, which is over six times the percentage of these groups in the general population according to the U.S. Census Bureau.¹¹

Over 80% of patients (see Table 7) come to the free clinic for primary care services categorized as basic preventive or curative care. It has been shown that health outcomes are improved when patients have a regular source of health care from a physician that knows them over time and functions for the patient as the nucleus of a medical home.²¹ Having health insurance can be represented as an access to health care services as well, including a medical home. Minorities and low-income individuals are less likely to have private health insurance.²² However, having a medical home reduces the negative impact of racial, ethnic, and gender variables.² Many individuals have no other source of medical care than the free clinic, and therefore do not have a medical home per se, and may need to use free clinics as their most frequent and reliable source of health care services.

The free clinic provides approximately 1,000 visits in a year while being open only one night per week. A typical night may involve seeing 20 or more patients and occasionally referring the patients to specialists or hospitals for follow-up. Rarely, the clinic manager may need to call local paramedics for an EKG or to transport a patient with uncontrolled hypertension to the hospital for emergency treatment and acute management. A few times per month, patients receive physical therapy services for musculoskeletal injuries, both acute and

chronic. All of this information provides the backdrop and context for the meaning that participants assign to their experiences as free clinic volunteers.

Methodology

The purpose of this study was to gain an understanding of the meaning of the volunteer experience from both professional health care workers as well as lay volunteers volunteering to provide health care at a free clinic in the Midwest. It is through the viewpoint of these volunteers that we can begin to understand the various meanings that their service and their volunteerism have in the context of our current health care crisis. In this paper, I will endeavor to assimilate the views and meanings that free clinic volunteers ascribe to their volunteer experiences with uninsured and underserved patients.

There are two methodologies that inform the framework of this qualitative research, namely ethnography and feminist methodologies. Drawing upon traditional qualitative methodology, ethnography is a study of a defined group, such as an organization, institution, or population. Through observation and interaction with its members a comprehensive picture develops, providing for the analysis of multiple perspectives.²³ Rooted in anthropology and sociology, ethnography is a form of qualitative inquiry in which the relationships of the participants, the cultural norms of a group, and the basis for the interactions with internal and external parties are central concerns to the researcher.^{24,25}

Further, essential to the research design itself are feminist methodologies²⁶ Core principles of feminist methodology are those that give emphasis to the elimination of power inequities between researcher and participant, recognition of the participant and researcher relationship evolving through the course of the dialogic nature of the interaction, acceptance and desirability of the relationship of the researcher and participant as open and reciprocal,

and the aspiration of the researcher to produce research that will contribute to social justice concerns.²⁶⁻²⁸

Feminist methodologies define and drive the features of the participant–researcher relationship. As distinctive qualitative research approaches, feminist methodologies can generally be described in terms of four main characteristics: (a) The primary analytic lens is the standpoint of the participant,²⁹ (b) insight into how the participant’s life is organized provides insight into power relations and the impact of social policies and institutions on the everyday lives of participants,^{29,30} (c) conscious efforts are incorporated to break down interpersonal barriers between researcher-participant relationships,²⁶ and (d) the researcher practices reciprocity in the research setting.²⁶

Given that the purpose of the research was to gain a deeper understanding of the volunteers as they interact with patients and each other in the context of the free clinic environment, development of open relationships that demonstrated reciprocity and respect was critical. As a physical therapist, I provided patient care as needed, but primarily became involved in clinic operations and clerical support, which greatly enriched the study findings. My own volunteer service was, in part, evidence of my sustained and strong belief in the principle of reciprocity. My volunteer participation allowed me to “give back” to the free clinic, the community center, and the participants in a nonexploitive and nondisruptive manner, while still learning about the culture of the free clinic and the perspective of the volunteers.

The training and orientation I received from the clinic manager allowed me to become integrated into regular clinic operations including use of pharmacy assistance programs to assist patients in obtaining low-cost or free pharmaceuticals. As one of the

regular volunteers, my relationships with other volunteers were on a peer-to-peer level and served to reduce any power differential due to my position as the researcher. Finally, my desire to volunteer each week was motivated by belief in the mission of the free clinic and true to feminist methodologies' underlying theme of impacting social justice concerns. The study was greatly enriched by this volunteer experience.

Feminist methodologies recognize the continuum of relationship possibilities between the researcher and participant, and encourage reciprocity.²⁶ This degree of openness is contrary to normative patient–professional boundaries in health care professions education. However, overt sharing of personal stories and expressions of feelings between the researcher and participants in this study formed the basis for the dialogic nature of the interviews.

The volunteers who participated in this study contribute to the continuity and stability of the clinic. They represent the rhythm of the clinic and therefore comprise a rich source of understanding about the free clinic. The participants' sharing of their own experiences provided insight into the meaning of their volunteerism and a deeper understanding of the free clinic in the context of community.

Methods. I collected data over a five-month period at a free clinic located in a community center in a Midwestern suburb.^d I purposively selected the free clinic from other clinics in the free clinic network because of the maturity, stability, and sophistication of the clinic operations as well as the arrangement of the office space. The executive director of the

^d The clinic and community center names are not identified for purposes of this article because doing so would logically lead to the identity of the participants who have been assigned pseudonyms and for whom I am protecting anonymity to the extent possible.

statewide free clinic network gave written approval prior to the initiation of my participant–observation experience.[°] Lay and professional volunteers were recruited as participants upon the recommendations of the clinic manager. The clinic manager was crucial to my understanding of the volunteers’ availability, suitability, and receptivity to the study design.

Participants. The free clinic volunteers selected as participants included key individuals such as the clinic manager and his wife who together organize and manage the volunteer schedule, finances, medical and office supply inventories, and the relationship with the community center. All five participants had tenure as volunteers with the same free clinic. I interviewed the participants about services provided at the clinic, their interactions with the patients, their perceptions of patient needs, their role at the clinic, and their motivation for volunteering. To better understand the findings, it is helpful to understand the background and role of each participant as briefly reported below:

Dennis: EMT, LPN, and free clinic manager. Dennis, a 41-year-old White male, is a licensed practical nurse (LPN) and volunteer coordinator and clinic manager. He has been the driving force behind the clinic from its inception 10 years ago when the free clinic started in a local church basement. As a full-time emergency medical technician (EMT) and director of emergency services for the community, he is extremely knowledgeable of available medical resources in nearby cities, towns, and counties. He recruits medical volunteers from his frequent contacts with physicians in local emergency rooms and hospitals.

Bernita: paralegal and free clinic office manager. Bernita, a 42-year-old female, is the office manager. This unofficial title is one conferred upon her by other volunteers

[°] This study was approved by the Institutional Review Board at Iowa State University in Ames, IA, January, 2006.

because of her familiarity with clinic operations. Dennis and Bernita are at the clinic every Tuesday night the clinic is open. She brings continuity and natural organizational skills to her volunteer position from her experience as a legal assistant and office manager at a local law office. Dennis and Bernita have two sons, one in college and one in high school.

Forrest: MD, physician. Forrest has volunteered at the free clinic for about five years. He is a 50-year-old White male physician, whose professional practice is in hospital emergency departments and primary care. He has a broad perspective on health care services in the city and across the state because of his interest in health policy and his administrative experience at local hospitals. He is very supportive of the free clinic mission and has in-depth understanding of the local health care safety net.

Emily: patient and free clinic receptionist. Emily, a 45-year-old White female, volunteers as a front desk receptionist. Emily and her family live down the street and have been patients at the clinic in the past. She knows many of the patients on a first-name basis because they are from the neighborhood. Emily works fulltime at a sales counter in a retail computer store.

Mary: RN and free clinic nurse. Mary, a 51-year-old White female, is a registered nurse whose professional work focuses on hospital and physician office quality improvement activities. Her current position at a for-profit medical foundation allows her to influence health care delivery to a larger extent, whereas her free clinic volunteer time gives her time in patient care. Mary, a friend of Dennis and Bernita for over 13 years, started volunteering when the clinic first opened in the church basement.

These two men and three women bring unique backgrounds to their volunteer work yet share a passion for the important services that free clinics provide to the community.

They all have varied life experience in employment, education, and patient care. The common denominator in their volunteer experience is their relationship with Dennis, the key individual whose passion for the free clinic mission made him instrumental in founding the free clinic. Each volunteer has been with the clinic at least five years. It is these volunteers and others that keep the clinic going week after week, year after year.

Data collection and analysis. I conducted one semistructured, in-depth interview with each participant at a time convenient to them and at a location familiar and accessible to them such as the free clinic itself, the local medical school, or the participant's residence. Each participant selected the pseudonym used to identify him/herself for recorded interviews, verbatim transcription, and field notes. After all personal interviews were completed, a focus group was held at the community center computer room and lounge adjacent to the clinic space. These data were augmented with extensive field notes recorded during and after weekly clinic hours.

My field notes included observations and reflections on my experiences as a volunteer, the clinic operations, and personal interactions with patients, family members, and volunteers. My 12 months of field notes formed the basis of triangulation of interview and focus group data.³¹ My weekly presence allowed me to seek additional understanding with participants during the research and significantly contributed to the validity and reliability of these data. Within 2 months of the participant interviews, I facilitated a focus group at the community center. A final follow-up meeting, known as a member check, was held with each participant allowing each to review the research findings, provide clarification to direct quotes, and supplement the initial interview data.

I used open coding methods to analyze interviews, focus group transcripts, and field notes. Open coding is the process of developing themes emerging from the data.³² In this process, I categorized the data into broad themes according to participants' responses to interview questions, focus group responses, and other dialogue among staff and patients in my field notes. These multiple data points were important to understanding various perspectives juxtaposed against my own background in health care delivery and administrative experience at a health insurance company.

Results

“What would they do if we weren't here?” All of the volunteers expressed recognition that the services they provide make a significant difference in people's lives, especially since the patients themselves may be invisible to the community at large. “Most people would be surprised that we need a free clinic in this community because it is seen as wealthy,” Dennis commented. He went on to say that in talking with others in the community that “most people don't think there is a problem in this suburb.” Bernita noted that the community is changing and “free clinics are needed in upper class communities, too, because there is such a need for health care now for average people.” The participants agreed that there seems to be a greater and greater need for free clinics because of layoffs as well as the increase in the immigrant population in the city and surrounding area. It is more difficult for patients to find a medical home and access health care if they are encountering economic pressure. “We feel like we are really making a difference and that people would not come here unless they had no other choices,” Forrest stated.

The overwhelming need for free clinic services by patients was summed up by Emily's comment, “I don't know what they would do if we weren't here every Tuesday

night.” Emily knows from her own family’s situation that having a free clinic in the neighborhood means that families will actually get affordable health care without having to take time away from school or work and without the typical wait to get an appointment at a regular doctor’s office. Sometimes this is the only reasonable alternative to being able to see a doctor.

Only because of a shortage of physicians and nurses would any patient who shows up on a clinic night go untreated. Bernita explained,

If we only have one doctor here for two hours, there may be a limit to the number we can take care of, but we really try not to turn anyone away. Especially if they’re sick, we always see someone who is sick. But we may ask someone who is here for a physical^f if they come the next week or refer them to one of the other network clinics.

We hate to do that, but sometimes it is necessary.

Emily also said that as the receptionist she makes sure that if there is someone in distress that person is moved to the front of the line and taken to an examination room right away. “You feel so badly for someone that is that sick, and you know they probably have been sick for awhile and had to wait until we’re here on Tuesday, when we’re open.”

I, too, wondered what would come of the small two-year-old Hispanic girl with a severe cough and fever that arrived at the community center on a night the clinic was not open. While the grandmother held the small child wrapped in a blanket for warmth, she tried to gesture and communicate that she had been told to come to the clinic by her daughter.

^f Some of the local employers, such as daycare providers and nursing homes, for example, refer their new hires to the free clinic for a pre-employment physical examination. Infants, children, and adolescents are seen for daycare, pre-school, school, and athletic physicals.

Even though the grandmother did not speak English, an older child explained that their mother, who works two jobs, is out looking for a place for them to move to from their apartment. Their grandmother drove them to the community center so the little girl who had been sick for five days could see the doctor that night. I attempted to send them to another network free clinic across town, but found that after trying to give them detailed directions, I was concerned that they had understood what I was saying and would not find the other clinic on a cold, dark, and rainy night. I decided to have them follow me in their car so we were not too late for them to see the doctor. Fortunately, the clinic had not yet closed for the evening but all the patients were gone and the nurse was already in the midst of packing up all the supplies after a very busy night. The doctor and nurse agreed to see one more patient who was in desperate need of health care. We made it just in time.

“It just draws you in.” The volunteers described their continued motivation for volunteering as “habitual” or even additive because of how they feel during and after the experience. Dennis solicited each of the participants to be volunteers after getting to know them personally. Forrest stepped up to the plate when asked by Dennis.

When I heard that the clinic was operating with one physician every week for years by herself and no one else, I said, ‘That’s not right. Sure I can do this!’ I volunteer only about once a month or so. There are times, on the way over to the clinic after a long day, I sometimes feel frustration but that quickly is replaced with joy after I have had a chance to talk to patients and make a difference for them.

Dennis is a member of the lodge that provides the major financial support to the free clinic each year. He reflected on this long-term relationship between the clinic and the lodge, saying, “Supporting the free clinic fits into the mission of the lodge to take care of those in

the community. This is really a good fit for both groups.” When asked about how he recruits volunteers, Dennis said, “Shame is a wonderful thing!” Dennis appeals to the health care professionals’ sense of altruism and professional obligation as he describes to them the important services provided at the free clinic. He smiled as he said, “I tell them to give it a chance and just do it once. I never have to talk them into coming back. They all come back because it is so rewarding. [Volunteering] becomes habitual and draws you in.” Forrest also commented that he “feels a sense of professional duty” to give back to the community and finds that being at the free clinic is one way to honor that value he holds dear. “Every health professional should do something like this. It is part of the responsibilities to society of being a health care professional,” he exhorted, “and there is such a great need.”

What kind of individual volunteers for this kind of work? Dennis replied, “I think that ultimately, the kind of individuals who volunteer to do this work, have that inbred, have that caring—it’s automatic. Obviously it takes a special person—part of their normal psyche.” Emily said, “It feels good to help. You get hooked!” Emily said that everyone is nice to the patients, demonstrates caring, and is genuinely concerned about every person’s well-being. “It feels good when patients show their appreciation,” she said. Why does she volunteer? “Well, because it is a ‘good thing,’ and I can give back. I don’t feel like I have to, but that I want to.” For Bernita, Forrest, and Mary, they, too, feel an intrinsic sense of fulfillment from the volunteer work they do. This in itself is reinforcing and motivating and is one of the things that keeps them volunteering year after year. Expressing caring, contributing to the community by “giving back,” and meeting a personal and professional calling are interwoven in the meaning of volunteering to these participants.

“It doesn’t feel like a free clinic.” Bernita said that this clinic “doesn’t feel like a free clinic. We offer a level of professionalism, like a regular doctor’s office.” The volunteers take pride in the services they provide. Patients often comment that staff are friendlier at the free clinic than other health care offices and hospital facilities. Are the services here the same as compared to the regular doctor’s office? “No, it’s better here! We’re spoiling them!” Mary said, and laughed with joy. Emily and others said that “we hear that all the time from patients and families, even in comparison with the other free clinics.”

Volunteers take pride in making sure that the experience of the patients shows respect and that people are treated courteously. “The number one reason that patients come to the clinic is because of cost and secondly it is the time of day, after work and after school,” Dennis said. He went on to explain, “Typically those not working don’t have insurance. Even those patients with Medicare or some other insurance can’t afford the prescription drugs.” Dennis said, “We never want the patients to feel that anyone is looking down on them or their situation or that they are getting inferior care.” Emily added,

Those employed with insurance struggle to get time off to go to the doctor’s office.

They can come to the free clinic in the evening and not have to take time off or lose pay by leaving for a doctor’s visit. When people come here we want this to be as good an experience as they can have under the circumstances.

Emily went deeper by saying explicitly, “We never judge the patients. It is not our business as to whether they have the co-payment of \$20 or not.” Dennis concluded,

Most people don’t feel like they are at a free clinic. In fact we feel pretty blessed with the nice clinic that we have, and the patients feel pretty blessed after they see us, and they tell us that. That’s the type of service we want to provide.

“The clinic is here as a stop-gap measure.” Invariably the clinic schedule is extremely busy each evening of operation. Emily and Bernita recognize many of the patients from previous visits over the year. Nonetheless, the free clinic was never designed to be the source of regular medical care for individuals. As Dennis explained,

The free clinic is here as a stop-gap measure to help people out until they can get back on their feet and into the regular health care system. Sometimes a person falls on hard times and doesn't have insurance, so we are a place they can go until their situation improves. We simply can't be a medical home because we can't perform all the follow-up that some patients need or be responsible for coordinating their health care.

Nonetheless, there are increasing numbers of patients seeking more than episodic health care services at the free clinic, especially Hispanic families, the participants said. “Usually if one member of a family comes, we end up seeing them all,” Dennis observed. The staff members have all volunteered for several years and believe that many patients are not getting health care anywhere else except the free clinic. It becomes difficult to reconcile the fact that, even though the clinic is intended to be a temporary solution for lack of health insurance, it often becomes a permanent answer for others who never escape their plight. “We don't doubt that people who come here really need to come to a free clinic. I am not worried that people are ‘abusing’ the opportunity to get health care here,” Dennis said. He went on to say,

We don't take appointments and we are only here one night of the week. That makes it inconvenient enough for people, that people that are here need to be here. These patients will only use the free clinic if they have to. Some of them do come here

pretty regularly, but then we don't see them. Hopefully that means that the system has worked and they have gotten connected with regular health care. That's what we're here for.

If a person only has some minor illnesses over the years, the free clinic can manage those fairly well and does.

For many adolescents we take care of them each time they are sick with upper respiratory infections or the flu and the parents use our clinic more or less like their regular doctor's office. As long as the illness is pretty simple, we can handle it, Dennis explained. Mary said, "Really, we can only take care of what has brought them to the clinic that night. We are not equipped to manage all of their health problems or more than what is the most urgent need right then."

During the focus group, Emily reiterated that despite what the health care professionals say, as a lay person she knows that the patients don't have other options and are looking for a place for regular health care, what might be called a medical home. They like the care they receive from the volunteers at the free clinic. Dennis was quick to reply that this is "risky for the patient because the free clinic is not set up to be the medical home. We are ignorant if we think otherwise." I asked Dennis to elaborate on why he believed this type of regular care at the free clinic was "risky" when the patients clearly perceived the care as high quality from caring professionals and as good as or better than what they would receive at other places. "This is really episodic care and focused on the patient's complaint of the night," he said. "Especially for chronic diseases, that need medical follow-up like diabetes or hypertension with lab tests, we really can't do a complete history and physical exam that would be required to manage the condition properly," he stressed.

Emily challenged Dennis' philosophy on this by emphasizing that:

from my experience, I can tell you I have been to the clinic here as well as my regular doctor. I can tell you that I get the same care here as I do at the regular doctor, and it doesn't cost me \$70! They take your blood pressure, and they tell you what it is, and its \$70! That's all they do!"

Dennis replied,

The danger of that though comes from the patient not being educated from a medical perspective. It's not just taking the blood pressure that's important in managing the high blood pressure; it is all the lab work and the follow-up care. Those medications that prolong your life can quickly kill you because of the harm they can cause your liver and kidneys. So if the patients use us as their medical home, they're assuming a fair amount of medical risk. So, if we see you for a focused complaint to renew your medications, the goal would be to have the primary physician look at all your body systems because we are not going to do the labs that are required to do that. That's the dangerous part. Sometimes we make it too easy to get that quick fix. When people don't get the education [about their disease], they don't understand the significance of these medications when they are not tracked.

Mary jumped in to say, "The other thing we don't do the best is the patient education, because the regular doctor's offices have the tools such as handouts. Besides that, we really don't have the time, room, or staff to do that."

Emily noted that she does not understand or necessarily agree with the philosophy of not encouraging follow-up medical visits for patients with chronic health care conditions. She said, "As a patient myself, I think I actually get more attention from the doctors here and

this is a friendlier atmosphere, too. Most of the patients comment that they really appreciate the services they get and how they are treated.” Even though Dennis, Mary, and Forrest, as health care professionals, would be quick to say that for diseases like diabetes or high cholesterol the free clinic volunteers cannot adequately perform all the management and patient education services that are truly the responsibility of the primary care physician, Emily argued, “But the regular doctors don’t do this!” Emily decried the situation by saying, “So that makes it hard for patients like me to put myself out to go my regular doctor and pay the co-payment which I can’t afford, when I get better care here.” Emily’s views seem to represent a growing trend in more patients with chronic illnesses that come to the free clinic for treatment or prescription drugs (see Table 6).¹⁰ Despite this difference of opinion between the participants, they all agree that the free clinic has a reputation for providing patient-focused care, viewed by patients to be of high quality. They understand that the free clinic simply cannot serve everyone for all their health care needs. They take pride and satisfaction in knowing they are doing the best they can under the circumstances and that they are but one thread in the health care safety net.

“We make choices or people wouldn’t get care.” When asked about any issues, problems, or barriers that the participants encounter during their volunteer experience, they unanimously agreed that “the *only* barrier is the language barrier!” as Mary put it, referring to patients who do not read, speak, or write English. She explained further, “Usually the patients are good about bringing an interpreter.” Bernita chimed in, “Sometimes there’s a third party waiting with another patient that we can pull in so that we are not just relying on the patient themselves or the children.” There are situations when the participants go out to the community center to find help. “Usually these people see how much trouble we are

having,” Benita said, “and they actually volunteer, and they will come up and ask us if they can help us.”

Many of the adult Hispanic patients have difficulty speaking English, which makes the medical visit more difficult. Emily has had some experiences at the front desk where it was very difficult to understand the patients. In one case, a patient waited two hours only for Emily to find out that he wanted to get shoes at the Clothes Closet and not be seen by the doctor at all. “I felt really bad for the poor man,” Emily said. “He was trying so hard to tell me what he needed, and there was no one around who spoke Spanish. We just try to make do and hope these things don’t happen too often.”

Mary identified one of the issues that is associated with the language barrier, “What’s tough for me is that you’re taught in the hospital you should never use that family member, because the problems that you get into is that you tell the patient something and the family may interpret that differently—are they really interpreting apples to apples,” she commented as more of a statement than a question. She then shared how the issue of not having interpreters is an issue for her by saying,

Not knowing what the child is saying to the patient makes me be a little hesitant to do this. Yet [the free clinic] is a completely different atmosphere, and we have to use what we have. You have to trust what you’re told in the scope of the situation for that patient. Patients and other nurses have been overheard discussing the fact that, for adult patients, it becomes particularly awkward for the children who speak both languages to interpret for their parents or family members when the health care information is especially personal or viewed by the patient as particularly sensitive. Dennis does try to obtain a medical translator,

but oftentimes finds they are unavailable on such short notice. Understandably so, this is not an ideal situation.

Dennis elaborated on another practical concern by saying,

There are some instances, and it's certainly not uncommon, where we ask seven- or eight-year-old kids to interpret for us as the doctor gives instructions for medications and follow-up. You or I, in our right minds, would not expect our seven- or eight-year-olds to understand this in English, yet we are asking these seven- and eight-year-old Hispanic children to convey to their parents in another language what the instructions are. I worry that the message we are giving gets distorted, like the telephone game. That the message we are sending is not the one getting delivered.”

When asked whether or not it is “acceptable” for the staff at the free clinic to compromise the standard for medical translation in health care,⁸ Mary said,

I don't think we have a choice. Because there are no other choices. It could be an emergency situation. Most times it is not. Usually you can ask enough questions of the patient or from the family member to the receptionist, to the nurse, to the physician. Eventually the three of us can come up with enough to be able to take care of the patient appropriately. We can't begin to follow as close a guideline as the hospital or we wouldn't be able to perform the care that we do. If we didn't do what

⁸ Several health care facility and quality organizations, licensure laws, as well as federal guidelines including the Health Insurance Portability and Accountability Act (HIPAA-AS) require health care professionals to protect patient confidentiality. There are established guidelines for medical translation service and specific training for those individuals who act as interpreters in a medical setting.

we're doing we would have to turn people away from getting health care services entirely. If we don't make choices, people don't get care.

The participants pondered whether or not the lack of an interpreter has ever caused an adverse medical outcome. They all seriously reflected upon the potential of an untoward event as a result of not understanding the patient's condition. As a group they believed that for each patient the right steps have been taken and that, if they err, it is on the side of patient safety. They agreed they don't know for sure. Without exception, the participants all agreed that the services at the free clinic are better than nothing at all and, therefore, acceptable to be performed in the manner in which they are doing so.

Although the greatest number of non-English speaking patients are of Hispanic origin, there are a few other situations in which interpreters are needed for medical translation. For example, periodically non-English speaking immigrants from countries and regions such as Bosnia, Croatia, Nigeria, Congo, Somalia, and China come to the clinic. They, too, have difficulty filling out forms and communicating with the staff, even if a family member or friend is with them. Sometimes they are not able to give a date of birth or communicate about their past medical history. It has also been observed that sometimes this communication barrier results in the clinic obtaining incomplete information as found in the quarterly reports as "unreported," "refused," or missing data (see Tables 4-7).

"If you are not a citizen, you can't get drugs." Another issue for patients who have immigrated to the U.S. is whether or not they are legal residents or citizens. To be certain, this is not an issue for the free clinic staff. They provide compassionate and high quality service regardless of legal status. In fact, the health care providers never discuss this with patients. However, up until recent time the registration form did not have formal questions

directed at patients asking about their residency or citizenship status. Bernita explained that what is different now is that the clinic is making overt attempts to get access to free or low-cost prescription drugs for patients. As a result, the clinic has set up a new system to capture all the pertinent patient information during the intake process.

Bernita advocates for patients through pharmacy assistance programs (PAPs)^h and has used the web-based computer software that each pharmaceutical company provides. This is a time-consuming process and even requires that she perform follow-up with the pharmaceutical companies on her own during her personal time. She is familiar with at least two different web tools to assist with obtaining prescription drugs: (a) www.needymeds.com³³ and (b) RxAssistPlus.com through Symmetrics, Inc.,ⁱ both intended to shorten the administrative burden of the application process. The participants agreed that the application process, although available to regular doctor's offices, would likely not be used by private physicians because of the time and complexity involved in the PAP process.^j

Bernita said,

^h Pharmacy Assistance Programs (PAPs) have been established by all major pharmaceutical company foundations.

ⁱ RxAssistPlus.com through Symmetrics, Inc is a proprietary software tool available to health care providers to expedite the tedious application process to PAPs. The Free Clinics of Iowa has provided training to their member clinics but does not require clinics to buy this product. Table 7 lists the types of health care organizations that are licensed users of [RxAssistPlus](http://RxAssistPlus.com).

^j The PAP process can take as long as two hours or more for one patient for one drug.

I'm finding that some immigrants are afraid of telling us if they are legal residents or U.S. citizens. Most of the non-English speaking patients leave that part of the form blank. We don't know why they do, but it is not uncommon.

With the current hegemonic discourse in the U.S. around immigration reform, border control, and deportation, the staff are conscious of the sensitivity for patients about sharing this information with anyone. "We just respect them and only ask them about this again if the doctor refers them for a prescription drug through the PAP. Otherwise, we just leave it blank and don't push the issue," Bernita said.

Bernita said,

That PAP system really puts immigrants at a disadvantage, especially if they are not working or are new to this country. All the PAPs want is proof of income and now most are asking about citizenship, too. If you are not a legal resident or citizen, your application will be rejected. It doesn't matter why you need the medicine. It is a frustration for me and the patients. It is very difficult to explain to the patients that they can't get their drugs. Sometimes they get really insistent, but I just tell them it is the policy and we can't do anything about it. There is nothing more we can do.

In spite of the frustrations with the PAPs, Bernita finds that the PAPs can really make a difference for patients if they qualify for the programs.

"They are ecstatic if we can give them drugs, too." Free clinics play an important role in dispensing medications for the treatment of acute and chronic conditions. Emily knows from her volunteer experience that most patients leave the examination room with drug samples, generics, or a prescription. Dennis said, "The patients are grateful for what you

have done for them, but they are ecstatic if we can give them drugs, too. Drugs are so expensive and our patients cannot afford to pay for them out of pocket.” Emily said,

Most of the volunteer doctors will not give more than a limited amount of sample drugs. Sometimes patients don’t understand this so I have to tell them that we cannot give them an unlimited supply of drugs. The patients don’t want to keep coming back for refills every 30 days. But I have to tell them we don’t have enough for all the patients we see now.

Forrest likes to use the PAPs because some of programs will give the patient a year’s worth of drugs for a chronic condition at low or no cost, depending on whether they meet the PAP financial eligibility criteria. He said,

I am trying to get patients connected to a reliable source of medications that they can afford, rather than the free clinic. I think that is part of my job to be sure that patients eventually find a medical home or can use one of the pharmacy assistance programs.

That means [the free clinic] can see more unique patients over the course of a year. However, what is hidden to the physician is that fact that the application process is fraught with what might be called “customer service” issues. Applications are returned by mail with various denial messages. Bernita expressed her aggravation at the entire system by saying,

It appears that there is no real concern for fulfilling the application in a timely way for the patient. They also appear to be really disorganized. The [PAP] company will write a letter returning the application stating the signed prescription from the doctor or the tax returns were not sent, when I know we sent it because we have copies of the application, prescription, and know that it was mailed with the most recent tax return.

The volunteers continue their efforts to provide affordable, accessible health care with available resources, persevering through the challenges, in an effort to help the patients who need it the most. But they all agreed that the PAP process is an example of a tightly managed, as well as a deceptively advertised program, that few can realize the benefits of due to the inherent barriers.

“Being able to just practice medicine.” The volunteers with health care education and licensure find the free clinic a place where they can provide health care services in an atmosphere of “freedom.” It is refreshing to be able to focus on medicine and not be bothered by the extraneous elements of the current health care delivery system like bureaucratic paperwork requirements and various insurance policies and benefit limits. Forrest commented that it is

nice to just practice medicine and focus on patient care, and not on billing insurance companies and the hassle of paperwork. Regular health care has really changed over the years and has become so weighted down with paperwork that doctors don’t get the time they need and want to interact with their patients. In some cases, the only focus of health care seems to be on reimbursement rather than what the patient needs.

Dennis and Mary are also motivated by this type of environment, but in addition find the opportunity to use their nursing training in patient care to be something tangible they get as a benefit of their volunteer efforts. “I get to play nurse once a week,” said Dennis, “because I can’t do that at my day job. This lets me keep up with my clinical skills so I don’t lose that.” Mary’s professional work is also administrative in nature and volunteering at the free clinic is the only way that she has a chance to use her nursing background on a practical basis. “I also get to work with different physicians and see how they do things. My

background is also in education, and I have the opportunity to mentor and supervise some of the nursing students.” Throughout the participant interviews volunteers emphasized that they are primarily motivated to contribute to the community and share a value of caring and helping others in need. However, for some of the volunteers there is the actual, realized benefit of the clinical experiences for their professional development and learning. For myself, I have valued the clinical experience in the same manner as Mary and Dennis. The free clinic provides the time and opportunity for me to practice physical therapy, which I would not otherwise have in my current administrative position at a health insurance company. When I renew my board certification next year, the clinical experiences from the free clinic volunteer hours will be an important portion of my professional portfolio.

Discussion

Volunteers engaged in service roles may have multiple personal intrinsic and extrinsic motivations for volunteering.^{6,34} The participants’ individual and collective experiences provide insight into their motivations and constructed meaning of their volunteerism. The three main themes derived from the data analysis are: (a) the sense of contribution and “making a difference” that volunteers experience by volunteering and by the manner in which they provide nonjudgmental services to patients who must rely on the free clinics for basic health care and prescription drugs; (b) the compassion that the volunteers feel for all patients, especially those from marginalized populations who have fewer options for obtaining medical services in the community; and (c) the conflict that volunteers experience over the patients’ need for a medical home and more comprehensive services against and the inability of the free clinic to meet all those needs.

“Making a difference” in the view of the volunteers is experienced on a personal level as knowing that they have helped the patients physically by the health care services, medications, and medical advice given. The volunteers sometimes wonder, rhetorically, “What would these patients do if the free clinic wasn’t here?” The unstated reply is, “They would do without!” Knowing the extent to which individuals and families depend on them only strengthens their resolve and commitment to the volunteer service they provide. Perhaps even more importantly they know that *how* they provide these health care services is just as important for the patients’ overall experience with and preference for the free clinic as their provider of choice.

The respectful and caring communication of the volunteers demonstrates the second theme of compassion that both motivates and “draws them in” to their volunteerism. They hear the expressions of appreciation from patients as well as the stories of job layoffs and subsequent lack of health insurance. Some of the stories of hardships, due to extreme life stressors, are filled with desperation. The participants volunteer out of a sense of altruism, which is congruent with their own professional beliefs and moral convictions. Sharing their own compassion in this way and relating to patients when they need such compassion transforms the experience to one that they describe as habitual or even addictive. Once they have started volunteering, they can’t imagine not continuing.

The third theme, which raises some semblance of conflict among the volunteers and within some individual volunteers, is the obvious discrepancy between the stated purpose of the free clinic to be a temporary solution for patients versus the patients’ actual need for comprehensive health care from a medical home. But finding a medical home is not likely if you don’t have health insurance and other financial resources. In the current health care

environment, seeking a medical home can in fact be dangerous if you are a noncitizen. The struggle with which volunteers wrestle is the dilemma over whether they should try to do more, provide more, and expand their services beyond what they are now currently doing.

As a safety net provider the volunteers do what is reasonable, but do not have resources to enroll patients in government programs such as Medicare or Medicaid, even if the patient is eligible and to do so would increase the patient's chances of finding a medical home. Ultimately attempt at all steps of the way to make decisions that are in the best interest of each patient at every encounter. They have chosen to provide health care services even when they have to do so in a way that may not meet an exact standard, as is the case with medical translation. In doing so, they believe that this is indeed preferable then turning any patient away and doing nothing at all. It would be hard to argue against that.

The free clinic volunteers are motivated to provide high quality health care at the free clinic. Preserving and enhancing the dignity of all of their patients is intrinsic to that care. They meet patients whose experiences with the health care system could be characterized as disastrous and inhumane. The patient stories are sometimes so overwhelming that it would not be surprising if the volunteers found the volunteer work that they do trivial in comparison to what seems like insurmountable problems of the uninsured and the health care system at large. Rather than becoming discouraged, their response is quite the contrary. All the participants are buoyed by their volunteerism and believe that they are making a very real difference in patients' lives.

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Table 1: Poverty rates of the state, county, and city where the participating free clinic is located

	Poverty rate
State	9.1%
County	8.6%
City	4.5%

Source: US Census Bureau, 2006 State and County Quick Facts. Available at

<http://quickfacts.census.gov/qfd/states/19J1983910.html>. Accessed September 15, 2006.

Table 2. Free clinic patients by gender ($N = 197$; 4th quarter, 2006)

	Number of patients	Percent of Patients
Female	128	65
Male	69	35
Total	197	100

Table 3. Age of patients receiving services at free clinic ($N=196$; 4th quarter, 2006)

Age range (years)	Number of patients	Percent
0-5	21	10.7
6-12	16	8.2
13-17	17	8.7
18-24	13	6.6
25-44	61	31.2
45-54	0	15.3
55-64	12	6.0
65+	16	8.2
Unreported/refused	10	5.1
Total	196	100.0

Table 4. Insurance status of patients seeking services at free clinic, $N=197$, 4th quarter, 2006

Type	Number served	Percent
Uninsured	135	68.5%
Medicare	9	4.6%
Medicaid	6	3.1%
Other Third Party	16	8.1%
Unreported/Refused	31	15.7%
Total	197	100.0%

Table 5. Reason for visiting the free clinic instead of “regular” clinic ($N = 195$)

Reason	Number Served	Percent
Hours of Operation	44	22.6
Cost of Health Care	99	50.8
Other	34	17.4
Unreported/Refused	18	9.2
Total	195	100

Table 6: The racial make-up of suburb vs. free clinic patients, 4th quarter, 2006

	Suburb ^a	Free Clinic
White	92.7%	57.4%
Black or African	1.9%	12.2%
Asian	2.8%	1.5%
Hispanic ^b	3.0%	25.3%
American Indian or Alaskan Native	0.1%	0.0%
Two or more races	2.6%	0.5%
Unreported	3.1%	

^aSource: US Census Bureau, 2006 State and County Quick Facts.

<http://quickfacts.census.gov/qfd/states/19J1983910.html>. Accessed September 15, 2006.

^bAlthough the US has determined that the appropriate reflection of the diversity of patients is best stated in the demographic of “Hispanic or Latino” when collecting census or demographic data, the free clinic network uses single word “Hispanic” on their registration/intake form.

Table 7: Category of services and patients served at free clinic ($N=197$; 4th quarter, 2006)

Type of Services	Number served	Percent
Basic preventive or curative care	161	81.7%
Chronic care	21	10.7%
Urgent or Emergency	15	7.6%
Total	197	100.0%

Table 8. Registered users of RxAssistPlus.org^a by organization category and type

<u>Category of organization</u>	
Non-profit	81.5%
Government agency	8.9%
Other (usually “for-profits”)	7.3%
Private physician office	2.3%
<u>Organization type</u>	
Federally Qualified Health Center or look-alike	21.3%
Free or sliding scale clinic	17.9%
Hospital or medical system	13.0%
Free clinic association	11.8%
Government agency	8.1%
Referral network (e.g., “clinic without walls”)	3.8%
Foundation	2.4%
Private physician office	1.7%
Pharmacy	1.2%
Homeless shelter/agency	0.7%
Medical/dental association	0.5%
Other	17.6%

^aPersonal communication with N. Moore, Systemetrics, Inc., July 6, 2007.

CHAPTER 4
LISTENING TO THEIR VOICES: PATIENTS AS TEACHERS

A paper prepared for submission to the *Journal of Medical Humanities*

Pamela A. Duffy

Abstract

In this article I use data from my ethnographic study of a free clinic to analyze patients' experiences in health care settings. From that analysis I propose a pedagogical model to inform cultural competency training in health professions education. I use feminist Intersectionality Theory as the grounding for my pedagogical model. Equally important to the application of this model is the integration of this pedagogy with professional development for academic and clinical faculty who serve as role models and preceptors for future health professionals.

Introduction

So the fundamental message of the teacher for social justice is: You can change the world. . . . At that moment we realize that no teaching is or ever can be innocent—it must be situated in a cultural context, an historical flow, and economic condition.

Teaching must be toward something; it must take a stand; it is either for or against; it must account for the specific within the universal. (Ayers, 1998, p. xvii)

More than any other time, health care delivery is focused on ensuring that the multiple needs of diverse patient populations are identified and met in the most effective and efficient manner. Teaching health professionals students the requisite skills for patient engagement across the spectrum of patient diversity requires academic programs to orient their curricula toward communication skills and patient education, toward disease prevention and long term wellness, and toward patient empowerment and advocacy. To achieve these

goals, curriculum design must optimize learning opportunities and resources as well as apply appropriate pedagogical theory and models to cultural competency education.

There are significant disparities in health outcomes for racial and ethnic minorities in this country. These disparities are pervasive and are only partially mitigated by socioeconomic status (Institute of Medicine [IOM], 2003a). Some of the causes can be attributed to the same racist attitudes and behaviors manifested throughout society and found in other social systems and institutions such as education and employment (Anderson, 2007). The prevalence of racism in health care, as reflected in health outcomes disparities, has received national attention from policymakers and educators. One strategy to address this racism in health care has been to increase diversity of health care providers.

As found in preservice teacher education, the demographic characteristics of preservice health professionals do not reflect the demographics of the U.S. population at large (Betancourt, Green, & Carrillo, 2002). Simply put, significantly fewer numbers of physicians, nurses, physical therapists, and other clinicians from diverse racial and ethnic backgrounds are represented in health care delivery compared to the disproportionate percentage of White or Caucasian practitioners. The Institute of Medicine (2003b) has long recommended that recruitment efforts and resources be directed toward rectifying the fact that relatively small numbers of individuals of racial and ethnic minorities enter health care professions. Although a more diverse workforce is desirable, it is no guarantee of an improvement in health disparities or a reduction in individual or institutional racism. The fact remains that even in a diverse workforce other forms of discrimination such as ageism, sexism, homophobia, and other “-isms” may still exist. However, one step to improving the

delivery of culturally competent health care services in the U.S. is to increase diversity of health care professionals.

For the past 30 years or more, professional associations and medical education providers have implemented recruitment efforts in minority communities. Some of these programs have even reached out to elementary schools to get the attention of young K-12 students early in their planning for college educations and their future career or professional life. But the fact remains that, in the U.S., health care professions do not represent the racial and ethnic diversity of the population at large. The goal to increase the percentage of practitioners from racial and ethnic minorities has not been accomplished nor does it seem realistic. Apart from progress in gender equity reflected in increased admissions of women in medicine, longstanding recruitment programs of the past several generations have not produced a diverse workforce of health professionals. Absent that, health professions education programs must strive for success in improving cultural competence and create curricula that is rich with opportunities for students to learn about diverse cultures. Medical educators need to reconsider the pedagogical theories and strategies that have been used for cultural competency curricula.

Cultural competency training is viewed as the key subject matter area within academic medicine whereby health professions students will develop the skills, attitudes, and beliefs necessary to make a difference in racism and health outcomes disparities. In the broadest sense, this commitment to cultural competency takes into account the need to train academic and clinical faculty, who are the role models of the preservice clinicians. Despite research and recommendations to the contrary, a significant gap still exists in what the health

professions students learn in the academic program and what they then encounter as actual professional practice in the clinic.

Another identified concern in cultural competency training is curricula that are over-reliant on factual and stereotypical portrayals in multicultural education (Lattanzi & Purnell, 2006). Cultural competency curriculum based on “factoids” and “recipe cards” leads to reinforcement of over-generalizations and stereotyping attitudes and behaviors in students. Consequently students’ development of appropriate patient–professional relationships is not fully realized and ultimately impacts the type of health care services delivered to underserved patient populations.

Other identified gaps in health professions education are inconsistencies and incongruities (known or unknown) in the teaching within the academic program as contrasted with the supervised clinical environments and experiences¹. Even the best textbook and classroom teaching cannot repair the perception in the student’s mind that differences between the two settings are resolved in favor of the clinical setting. “That’s the way they do it in real life” will usually trump “This is the way it should be done” from the classroom lecturer. Student learning can be quickly extinguished when preceptors and professionals in the field do not reflect the appropriate cross-cultural attitudes and behaviors (Campinha-

¹ Academic programs sometimes perceive that they are “held hostage” (my words) by clinical internship sites because they can be in such short supply depending on the health profession in question and the environment at the time. This dynamic may lead to a dysfunctional or passive relationship between the clinical site and the academic program. In other words, they are just grateful to have the site available for student practical training. “Laissez faire” governance of these clinic internships perpetuates any identified or unidentified gaps and never achieves organizational or institutional change.

Bacote et al., 2005). As role models, preceptors or clinical instructors are perhaps the most influential factors in student adoption of professional behaviors as students develop self-efficacy and their own professional identity (Bandura, 1986). Therefore, even adequate cultural competency training will not be transferred to the clinical environment if incongruities are not rectified between academic and clinical education curricula. The gap between what is said (classroom teaching) and what is done (clinical role modeling) may be one of the most significant contributors to the ongoing struggle to transform health professions education.

Curricula should include training for students, and academic and clinical faculty, regarding patient–professional interactions and communication, multiculturalism, and cultural competency. Pedagogy and teaching methods in both the academic and clinical internships should be congruent throughout the duration of the professional program. However, benchmarking studies of best practices in the teaching of cultural and linguistic competency in health care education (Campinha-Bacote et al., 2005) do not emphasize theoretical frameworks that are foundational to pedagogy and curricular design. Therefore, in this article, I will define a pedagogical model to move medical education to a new stage of cultural competency training. This new pedagogy uses Intersectionality Theory as a meaningful antidote to the perpetuation of subtle and institutional forms of racism and discrimination that are present in health professions education and health care delivery in general.

Intersectionality Theory for New Health Professions Pedagogy

Pedagogical strategies to improve transfer of learning in cultural competency training in health care professions can be found outside of traditional medical education by examining

social science research. Kirkman and Anderson (2002) advocated for the integration of intersectional approaches to nursing scholarship, for example. “Acknowledging the interrelatedness of race, class, and gender provides important insights for post-colonial inquiry and guards against incomplete and simplistic analysis” (Kirkman & Anderson, p. 13). I propose taking this intersectional approach beyond scholarship and research and applying it as a basis of theoretical grounding for the pedagogy of cultural competency training in health professions education. The following section will therefore discuss the genesis of Intersectionality Theory² in social science.

Intersectionality Theory

The historical origins of Intersectionality Theory arose out of discourse and debate within the feminist movement from Black feminist thinkers and writers (Collins, 2000; McCall, 2005; Williams, 1994). Collins, for example, argued that fixed categories of identity and identification such as gender did not account for or fully describe experiences of all women, particularly Black women, and therefore, could not be held out as either inclusive or

² I have chosen to capitalize this phrase throughout the manuscript to emphasize a new application and a new domain (i.e., medicine) for integration of a traditionally feminist paradigm (Collins, 2000). Health care and medicine, except for nursing education, have not embraced feminist theory and methodologies to any extent (Kirkham & Anderson, 2002). So for this new conceptual and practical application of “intersectionality” it is worth drawing attention and emphasis to the term as it is introduced as a theoretical grounding in health professions pedagogy. In the context of medicine and health care, I don’t think this term can be “genericized”—at least, not now. Not until it is in common usage do I recommend small case reference to this theoretical construct. It is time for feminist theory, discourse, methodologies, and research to move beyond feminist theory, discourse, methodologies, and research into the public domain (hooks, 2000).

representative of all women's lives. The discord and continued reframing of what constituted feminist ideology and principles was heavily influenced by Collins' "Matrix of Domination," which sought to inform understanding of the social location of women (and other marginalized groups) through an analysis of their multiple, intersecting and overlapping sites of oppression/dominance and the impact that it had on identity, roles, power, and position (Collins; McCall; Williams).

Interest in intersectionality arose out of a critique of gender-based and race-based research for failing to account for lived experience at neglected points of intersection—ones that tended to reflect multiple subordinate locations as opposed to dominant or mixed location. It was not possible, for example, to understand a black woman's experience from previous studies of gender combined with previous studies of race because the former focused on white women and latter on black men. Something new was needed because of the distinct and frequently conflicting dynamics that shaped the lived experience of subjects in these social locations (McCall, 2005, p. 1780).

Feminists have embraced intersectionality as a powerful tool of analysis for understanding the relationships between multiple dimensions of social relations and social identities. Intersectionality Theory, used as the basis of analysis, can provide the knowledge necessary for marginalized groups and advocates to resist such oppression. In health care, advocates such as health care professionals, need to understand the environmental pressure(s) for marginalized groups is to adapt and submit to the dominant culture.

Domination operates by seducing, pressuring, or forcing African-American women, members of subordinated groups, and all individuals to replace individual and cultural

ways of knowing with the dominant group's specialized thought—hegemonic ideologies that, in turn, justify practices of other domains of power. (Collins, 2000, p. 287)

For health care education, particularly when addressing the health care of those who are underserved, or who are part of the minority demographic, integrating Intersectionality Theory in the analysis of patients' locations of domination/oppression and the intersection of gender, race, ethnicity, sexuality, ability, disability, and socioeconomic status of patients fundamentally breaks down any efforts to place patients into sterile, convenient categories for the comfort of health professionals or the teaching of cultural competence (Schulz & Mullings, 2006).

It is also critically important for health professionals to remember that patients are not merely a sum of their oppressions. They are also shaped by the strengths and resilience they embody. Patients who face challenging daily lives, who carry memories of past abuse, who endure numerous indignities, subtle as well as not so subtle, are not defined by these difficulties. Patients from marginalized groups indeed experience and share joy, growth, happiness, and satisfaction in their lives. Being a culturally sensitive health care practitioner means to remain open to all facets of the person, the patient.

I will now describe the application of Intersectionality Theory as a grounding for health professions education pedagogy in cultural competence training. I have selected Purnell's model of cultural competence (see Appendix)³ for further explanation and description because, like Intersectionality Theory, it attempts to holistically consider human

³ Purnell's model of cultural competence is widely used in health and rehabilitation because of its holistic framework and complexity

diversity and complexity. Following the description of principles of cultural competency training, I will then explain how important Purnell's model of cultural competence is the basis of analysis in experiential learning.

Teaching Cultural Competency in Health Professions Education

Cultural competency training, combined with experiential learning, is being recommended and implemented at health professions programs throughout the U.S. (Bentacourt, Green, & Carillo, 2002; Lattanzi & Purnell, 2006; Reynolds, 2005, 2006). In this section I will describe some of the major principles of each and how they complement each other in health care education to improve health care delivery to diverse patient populations.

Cultural Competency

Cultural competency and cultural sensitivity have become shorthand phrases for a composite set or range of attitudes, behaviors, and skills necessary for an individual to interact respectfully, intelligently, and compassionately with individuals from backgrounds other than the majority, dominant culture (Benbassat & Reuben, 2004; Campinha-Bacote, 2002). Cultural competency has been variously described, defined, and positioned. Salimbene (2005) stated, "Culturally competent patient care is now recognized by the health community as having as much, if not more, to do with cultural understanding as it does with interpretation of medical information" (p. vii). Spector (2000) coined the phrase "CultureCare" to describe "professional health care that is culturally sensitive, culturally appropriate, and culturally competent" (p. 281).

The Institute of Medicine (IOM) referred to the importance of cultural competence in multiple contexts and publications including public health education and training and

eliminating health disparities among segments of the population (IOM, 2003a, 2003b). In *Who Will Keep the Public Healthy?: Educating Health Professionals for the 21st Century* (IOM, 2003b) the Committee on Educating Public Health Professionals for the 21st Century emphasized the importance of teaching cultural competence by stating it is a “systematic process” and contrasting that with cultural *sensitivity*, which is

rooted in developing attitudes of respect and appreciation for individual and cultural difference, and forms a foundation and rationale for cultural competence. . . . Cultural competence is based on an empirically derived body of knowledge that is translated and integrated into the curricula and an established stock of knowledge imparted in programs and schools. (p. 78)

Most importantly, they stressed that the process of transferring learning of knowledge into skill sets must be dynamic and infused throughout the organization [or curriculum] at all levels. I will now describe some of the important elements essential to successful cultural competency training for students or professionals.

Purnell's Model of Cultural Competence

Purnell's model of cultural competence (Purnell & Paulanka, 2005, pp. 6-19) is unique in its comprehensiveness and visual representation (see Appendix). This model presents 12 major domains of human culture with detailed subcategories. Purnell's 12 domains are as follows: Overview/heritage, Communication, Family roles and organizations, Workforce Issues, Biocultural ecology, High-risk behaviors, Nutrition, Pregnancy, Death rituals, Spirituality, Health-care practices, and Health-care practitioners. The model is organized to address the subjective culture of attitudes, values, behaviors and beliefs, rather than the objective or material presentation of culture evidenced in arts, music, and literature,

for example (Purnell & Paulanka, 2003). Purnell and Paulanka's (2005) *Guide to Culturally Competent Health Care* provides sample questions for health care practitioners to use when conducting a cultural inventory. These types of probative questions on cultural characteristics of patients may help gain cultural information, but must be used only as possibilities for points of dialogue for a cultural encounter, and not assumed to be required interview questions. In the hands of an uninformed clinician, the cultural questions may unintentionally cause patient defensiveness, seem intrusive, and/or be perceived as taxonomy rather than interest in the patient (Wissow, Larson, Anderson, & Hadjiisky, 2006). Purnell's model is an important representation of the breadth and depth of cultural information that can and perhaps should be considered in the cultural encounter(s).

Once students understand the definitions of the categories and subcategories of each domain, students need the opportunity to learn how to apply this knowledge base to interactions with patients. Purnell's model, appropriately filtered and interpreted through Intersectionality Theory, is a powerful tool. The nexus of this pedagogy and methods with cognitive theory then brings a great synergy to the planned experiential learning opportunities to support cultural competence skill acquisition in health professions education. It is important that the most important aspects of experiential learning be recalled to complete the understanding of this synergistic relationship.

Essential Elements of Experiential Learning

Experiential learning supports the development and transformation of both student and faculty, especially through shared reflection. Reflection, in the form of journal writing, for example, is the key to unleashing the transformative potential of experiential learning in health care education (Wong and Blissett, 2007). Teaching cultural competence in health

professions education programs must also include contextualization of the knowledge so that students understand the application of the knowledge base (Benbassat & Reuben, 2004; Campinha-Bacote, 2002; Conning, Hooper, & Turner, 2001; Dogra, 2001; Galanti, 1997; Kern, Thomas, Howard, & Bass, 1998; Leavitt, 2001; Masin & Tischenko, 2007; Ochoa, Evans, & Kaiser, 2003; Purnell & Paulanka, 2003, 2005; Salimbene, 2005; Spector, 2000). This is represented by applying Purnell's model of cultural competency as viewed through Intersectionality Theory to the context of providing services to actual patients in their own environments, interacting with a team of health care providers in a community setting, and gradually assuming responsibility for managing patient health care in the context of family and community. Experiential learning contributes to understanding of cultural characteristics as well as learning that these cultural identifiers are but mere contributors to one's identity, not the ultimate definition of personhood.

Spector (2000) coined the phrase "CultureCare" to describe "professional health care that is culturally sensitive, culturally appropriate, and culturally competent" (p. 281). But the question for health professions educators then is how best to develop students to deliver CultureCare. Obtaining cultural competency is generally thought to be a dynamic process and not a goal. Therefore, the development of cultural competency requires a learning environment that is conducive to student, faculty, and preceptor transformation (Merriam, 2004). Educators have found experiential learning to be a meaningful component of effective health care curriculum for integration of classroom knowledge (Beard & Wilson, 2006; Brown & Wise, 2007; Steiner, Calleson, Curtis, Goldstein, & Denham, 2005; Wood, 2001). Experiential learning may also lead to student transformation, as evidenced by change in

skills, attitudes, and beliefs; but not without the adoption of appropriate pedagogy to guide the curriculum and experiential learning (Glenn, 2002).

Consideration must be given to the characteristics that students bring to the experience, the characteristics and contributions of the community partner, and the coordination of the experience between the clinical and academic faculty members. The intention and application of curriculum design and learning theory are imperative for these community immersion experiences to be transformative (Beard & Wilson, 2006; Conning et al., 2001; Connors & Seifer, 2002; Kern et al., 2005; Merriam & Caffarella, 1999a, 1999b; Moon, 2004; Reynolds, 2006; Schon, 1987; Steiner et al., 2005; Yammill & McLean, 1999). Collaboration among students, faculty, and community partners is essential to maximizing the relevance and significance of the service learning experience for all stakeholders involved (Connors & Seifer).

Experiential learning is desirable as a curriculum application for many reasons, not the least of which is it “takes account of the functioning of the whole person, including her emotions” (Moon, 2004, p. 125). Many of the experiential learning curriculum models include student reflection as part of the design. Experiential learning in of itself does not necessarily assume reflection, and reflection itself requires guidance (Moon). Faculty can increase students’ ability to produce meaningful reflection by emphasizing the importance of the patient–professional relationship in the therapeutic encounter and asking them to draw attention to their own feelings, reactions, questions, and dialogue with patients. Cultural competence training also needs to assume that there is more intracategorical diversity than intercategorical diversity (Campinha-Bacote, 2002; McCall, 2005). In other words, racial, gender, and class inequality are not the same across all patients and their circumstances.

Therefore, Intersectionality Theory is useful as a basis of analysis of the cultural competence model as applicable to an individual patient.

Health care educators believe that student learning of cultural competency becomes transformative when theoretical concepts and multicultural knowledge are situated in experiential learning environments such as community-based primary care clinics. Students have the opportunity to interact and apply learning to health care conditions of patients from traditionally underserved populations. For these clinical contexts to be fully realized as transformative, students must be educated about health policy initiatives and the requirements of the health care delivery system to better understand the standpoint of the patients relative to social institutions and social relations (Smith, 1987).

The patients who seek health care from free clinics, for example, do so for a variety of reasons (Geller, 2004). Duffy (2006) found that patients find the quality of care and treatment by staff to be of high quality and respectful, especially compared to what they called “regular” health care in physician offices or hospitals. Treatment in the regular health care system is at times abusive, disrespectful, and also difficult to access because of barriers in scheduling, payment for services, and treatment by staff. In regular health care settings, patients perceive that the clinicians withhold educational information and treatment options because of their lack of financial resources and are treated differently than other patients. But even Intersectionality Theory is only useful in as much as it can be applied to the clinical setting where it serves as the theoretical grounding to an experiential learning model that includes reflexivity, appropriate role modeling, and close coordination between the education program and the community-based partner or clinic.

Race, class, gender, and other factors are not the least of which intersect to impact quality of life, health outcomes, and experiences in accessing health care (Beal, Doty, Hernandez, Shea, & Davis, 2007; Jackson & Williams, 2006). There needs to be consideration of the multiple grounds of identity when considering how the social world is constructed and the impact that subordination, domination, and oppression have on the individual (Williams, 1994). However, people in the medical professions already understand complexity! This way of thinking about intersectionality is the same way of thinking about co-morbidities of disease states. All I am saying is that for the culturally sensitive practitioner to see patients holistically and account for the complexity of their lives, this same way of thinking must be applied to social relations and the patients' multiple subjectivities.

As I describe the application of this theoretical basis the pedagogical model, I will use ethnographic data from free clinic participants to show that Intersectionality Theory can transform cultural competence training, enhance transformative learning, and achieve transformation of health professions education at all levels. The following selected participant experiences illustrate these multiple subjectivities and intersectionality of race, class, gender, ability/disability, and age.

Patients as Teachers

“I hope the doctor knows I am more than my condition at the time”

I have chosen two patient vignettes to help depict the difficulties that patients from multiple points of oppression and domination encounter in the health care system (Duffy, 2006). In these narratives, it is important to recognize that the context includes both “regular” health care and safety net providers. The participants shared deeply personal experiences and their reflections reveal each person's own sense of dignity and humanity. If misapplied, the

traditional cultural competence models could lead to simplistic and otherwise under-estimation of the complexities of these patients' lives. Before going further, a word of caution is appropriate. It is only fair to say that these vignettes do not have the benefit of corroboration or the contribution of the volunteer perspective. For that reason, it may be imprudent to draw conclusions from the vignettes about whether the volunteers' motivations or behaviors deserve criticism or whether the narratives simply expose the unavoidable and inherent realities of a free clinic "system" which cannot function as a medical home.

Both of these individuals, Mr. Ortiz and Michelle,⁴ have used the free clinic for more than a year and shared information with me in my role as participant observer that would otherwise not have been gleaned in the interviews alone. Their stories exemplify the importance of taking time to have dialogue with patients about family backgrounds, support systems, and any other social or economic issues to understand the patient's standpoint and life difficulties—what the literature calls "multiple areas of oppression." This truly will lead to culturally competent care and put the patient's health conditions and concerns in the context of their everyday lives. I'll begin with Mr. Ortiz.

"I need a place to be"

Mr. Ortiz is a 65-year-old Hispanic male who recently moved to the Midwest. He and his wife raised their five children in Texas where he worked as a supervisor with a government agency. After his wife passed away and upon retiring due to health concerns, he moved to the Midwest to be closer to his family but has had no regular source of income and could not afford his own housing. He lived with various children for months at a time

⁴ Pseudonyms have been assigned to all individuals with whom I became acquainted in ethnographic research of a free clinic in Midwest (Duffy, 2006).

without permanent housing. His daughter, Carmen, with whom he lives now, considers him homeless because he is “doubling up” with her temporarily. This temporary situation has existed for over a year, and she sees it as a “permanent” stress on her family. She works two jobs, is raising her own three children, and trying to get legal custody and eventually adopt two of her nephews. Mr. Ortiz says, “There is a lot of noise in the house with my daughter’s kids. It makes it hard for me to sleep and I don’t have any privacy. Of course, I am very grateful that she takes me in, and I don’t want to be a problem for her, but I need a place to be. This is very hard on my heart because I cannot get my rest.”

Mr. Ortiz started coming to the free clinic with various members of his family over a year ago. He usually arrives with his daughter, Carmen, or his son, Junior, and daughter-in-law, Becky, and they all sign up to see the doctor. He needs treatment for his chronic diseases and also comes in for any acute illnesses. He is eligible for Medicare but does not know how to access the system to become enrolled. He brings a list of over 25 drugs into the clinic to see if he can get any of his prescriptions filled. He is a soft-spoken, self-effacing gentleman who does not advocate for himself and, despite being well-educated, speaks with an accent and is sometimes difficult to understand. Sometimes he would visit the clinic weekly over a period of months. One of the medical volunteers said he thought that it was more “for the socialization, and not so much to see the doctor. It’s what they do on Tuesday nights, come to the clinic.”

One week when Carmen came to the clinic for herself, she asked at the reception desk if the receptionist or the doctor could write a letter of support so her father could get into a rent-subsidized senior living facility nearby. No one at the clinic would do so. They did not feel qualified to do so, they said. So I volunteered to provide the documentation as the

physical therapist who had observed his level of function, had knowledge of his overall health status, and understood his social and financial situation. I mailed the letter to the state agency so that his application could be evaluated; the number of apartments was limited and there was a greater need than there was availability for housing. Even if he met the criteria, it might be 6 to 12 months before there would be a vacancy. However, it would be worth whatever the wait to find a real solution to Carmen's overcrowded household and her overburdened level of caregiving responsibilities for her children, husband, and father.

On a particularly cold March night, Mr. Ortiz arrived in distress with Carmen and Junior and could hardly breathe or sit up straight. His arms were braced on top of the dining room table as he tried to take a few bites of his dinner. Sitting in the community center, bent over his plate, he wasn't able to eat and breathe at the same time. He had an ashen look to his face, and needed a wheelchair to get from the dining room to the clinic, less than 100 feet away. Mr. Ortiz saw one of the medical students and volunteer physician on duty at the clinic that night. Like he usually did, he very politely answered all the questions that the doctor asked him. He was given an antibiotic for an upper respiratory infection and told to follow up with the clinic next week if he wasn't better.

The next week when Junior came to the clinic, I asked him about his father, and he replied, "He was hospitalized last week with congestive heart failure. He was really bad off and I had to take him to the emergency room in the middle of the night after he was at the clinic. He'll probably be there another week." But he went on to say that his sister didn't know if they could take their father back at her house with all her kids and her work schedule. They didn't know what they were going to do and the doctors at the hospital didn't know for sure when they were going to discharge him to go "home."

They had a hard time connecting with the doctor at the hospital because he was never there when they visited Mr. Ortiz in the evening after work. Mr. Ortiz had a difficult time understanding what he was being treated for and what the doctors and nurses had planned for him. Carmen and Junior relied on the information they were given by the nurses. The children were at least happy he was in a safe place and someone was there to watch over him to make sure he got the right medicine, nutrition, and the tests he needed to find out what was wrong with his health. They were helping him get out of bed and walk to get his strength back. One of the nurses told them he might need some rehabilitation and physical therapy to become more independent. It would take some time for their father to get back to normal, they said.

Three weeks after Mr. Ortiz was admitted to the hospital he walked into the clinic with a cane to see if the doctor could see him for his back pain. He had been lying in the hospital bed for several days and even after he was discharged it was not getting any better. I saw him for his back pain and we had a chance to talk.⁵ The color in his face was good and he was back to his jovial self. He had been so sick when he was hospitalized he was afraid he “wasn’t going to make it.” I asked him about the senior housing and he said that he had been qualified by the state agency and was on the waiting list. There were eight people ahead of him.

When I told Junior how good his dad looked, he looked exasperated and said he wanted me to know the circumstances surrounding Mr. Ortiz’s discharge from the hospital. Carmen and he had been surprised when he got the call from the hospital one day and were

⁵ During the course of the ethnographic study of the participating free clinic, I was a healthcare volunteer as a physical therapist.

told to come and take their father home. They knew nothing about this. There was no advance warning, and they had been told a few days before that their father would need some physical therapy and nursing care to get his strength and endurance back. The doctor had come in early in the morning and asked Mr. Ortiz what he wanted to do, “Go home or go to a skilled care facility?” “Well, I don’t know,” Mr. Ortiz told the doctor. “I can’t make that decision without talking to my daughter, and she is not home now. She works two jobs. I don’t know what she wants me to do.” Mr. Ortiz was alone at the hospital when the doctor broached the subject of skilled care and he did not recall that anyone had mentioned this before. He did not want to disturb his daughter at work. The doctor emphasized that he had to make up his mind right away because he had to leave the hospital that day, and the doctor needed to know what to put in the chart. “Well,” he said, “then you’ll just have to send me home, because I can’t make that decision without consulting with my daughter to see what her wishes are, and she doesn’t get off work until 5:00 p.m.” Later that day, one of the nurses called Junior and told him to come and pick up his father. The family was very distressed that no one had talked to them about the options that might be available to their father at discharge. They were more upset that they had missed the opportunity to have his care transferred from the acute care hospital to the skilled nursing unit. It was so regrettable, they said. He was still weak and needed to get stronger so he could be more independent. As a family, they knew that he was getting frailer. Mr. Ortiz summed it up by saying sincerely,

I wouldn’t just leave my daughter’s house without telling her and have her think that I was deserting her. I wouldn’t want to make her upset by doing something that she didn’t think was right. So, the doctor sent me home.

As I will discuss below, Mr. Ortiz's family and medical histories as well as his experiences at the free clinic provide us with rich data through which to understand the importance of both approaching medical education with a foundation in Intersectionality Theory and for future medical practitioners to have mentored experiential learning that brings them into contact with patients like Mr. Ortiz. However, I will first present my second example.

“That isn’t how people should be treated!”

Michelle’s story is one of resilience. She is a 52-year-old White female married to a man nearly 20 years older than she. She has had a hard life, first with poverty and abuse as a child, then sexual abuse by men as an adolescent and young adult, and eventually quitting working due to difficulty coping with office environments and being around people. During the early years of her marriage, before the birth of her son, Terrence, she joined her husband hauling trailers over-the-road in their semi-trailer truck. They were a good team, she thought, and she enjoyed the time with him. But once she had a baby, she needed to be home and could not travel like she had been. During this time, she tried to find a primary care office for herself and her family, including her extended family of parents and sister who depended on her to coordinate their health care.

She started seeing one particular physician, Dr. Bailey, about 10 years ago when she felt like she was being mistreated and maligned at various medical offices. She was looking for someone who would see her at the end of the day when her husband was home. She also wouldn’t have to sit in the waiting room with all the other patients because it would have thinned out. Michelle’s anxiety and depression were interfering with her daily activities and

she needed medication to manage it. Sitting in the waiting room exacerbated those symptoms.

Dr. Bailey, a Black female physician about Michelle's age, was willing to accommodate Michelle late in the day. But when the doctor's office announced that they could no longer do so,⁶ Michelle pleaded with them to make an exception. Dr. Bailey met with Michelle and together they reached an agreement for Michelle to see Dr. Bailey at the free clinic on the nights she was the volunteer physician on duty.

Michelle's life has been complicated by a couple of things, all of which have contributed to her increasing obesity, anxiety, and depression. She also developed what appears to be a realistic fear of regular health care and health care providers. About five years ago, she was the primary caregiver for her sister who died an early death after initially being misdiagnosed. Shortly after that her mother became septic with a postoperative infection and relied upon Michelle for all of her "nursing" care at home. She died precipitously, and Michelle said she still feels like she is not over quite over it. During those illnesses, Michelle was the one searching the Internet for appropriate medical information and coordinating the care of her sister and her mother. She tried to communicate with the doctors and advise them of her sister's and her mother's conditions and their failure to respond to treatment interventions, but felt like she was brushed aside. Michelle is convinced that had they paid

⁶ Dr. Bailey became the medical director for a free clinic and was volunteering at the free clinic in the evenings. She had to change her office schedule and was no longer taking late appointments because it interfered with her free clinic work. The free clinic started in the basement of "Black Church" in a suburb of a large metropolitan area. This free clinic eventually moved to a community center location and was the participating clinic for an ethnographic study (Duffy, 2006, 2008) of patient and volunteer experiences.

attention to her reports and taken appropriate action in a timely manner, her sister and mother would be alive today.

Michelle called me at home one night after she had been to the clinic. Her voice was excited and rapid. She told me that the young male volunteer physician who saw her that evening questioned why she had come to the free clinic at all. Didn't she have insurance, he demanded. Didn't she know that the free clinic is not supposed to be her regular doctor? What was she doing, just trying to get drugs? When she tried to explain that Dr. Bailey had told her it was okay to come to the free clinic, he did not want to listen. Michelle pays for her own maintenance medications for anxiety and depression, but does need to have a physician write the prescription so she can go to the pharmacist. Usually Dr. Bailey would write enough for 6 to 12 months so that Michelle would not be inconvenienced by having to come back and see her frequently. Michelle was very capable of managing her own medication regime and Dr. Bailey knew this. The volunteer doctor, new to the free clinic, seemed "put out" and shrugged his shoulders when Michelle encouraged him to call Dr. Bailey to verify her story since he didn't seem to believe her. Instead, he gave her a prescription for a 30-day supply of her medications and dismissed her, telling her she should not come back for her chronic conditions.

I've got to tell you, I was so offended, and angry that my heart was racing. I can't get this out of my mind, how I was treated. And I had to stay because I needed my medicine. Now I will have to come back again to get the right prescription that I need. I just had to tell someone because that isn't how people should get treated, and no one at the free clinic has ever done that before. That's just not right!

I assured her that I would convey her feedback to the clinic manager. The clinic staff seemed unsurprised and uninterested in the feedback and would not commit to follow up with the young, male physician. Having another volunteer physician at the free clinic to provide medical services seemed more important than holding him, as a volunteer, to a standard of professionalism and interaction with patients.

Intersectional Analysis of Patient Experience: A Model for Pedagogy in Medical Education

In this section, I use Intersectionality Theory to analyze the Mr. Ortiz's and Michelle's experiences as impacted by their multiple locations of oppression and subordination (Collins, 2000; McCall, 2005; Williams, 1994). When analyzing Mr. Ortiz's and his family's experiences, there are some aspects to his circumstances and cultural identity which seem obvious and others which would only be apparent through a much deeper dialogue than what occurred in his recent interactions with multiple physicians and other health care providers. Mr. Ortiz is a Latino male, with family origins in Mexico. He suffers from many chronic diseases and is on numerous medications. In addition, he is homeless, older, and unable and uncomfortable advocating for himself with any of the health care personnel. His physical impairments have resulted in disability and inability to work, another category of subordination and social stigma. All of these circumstances leave him vulnerable to being marginalized within the health care system by those who are responsible to provide his care.

As these vulnerabilities and multiple areas of subordination intersect and overlap with each other, even greater vulnerabilities are created for him when he interacts with the free clinic staff, the attending physician, and the hospital facility. In getting to know Mr. Ortiz, he

shared with me that his family came from Mexico originally and he still has “people” there. The free clinic volunteers refer to Mr. Ortiz’s family as “Hispanic.” As his story is analyzed, one must first of all remember that he is Mexican-American and, according to DeGenova (1997), should not be stereotyped to be just like all other Hispanics, which as a group comprising many different subgroups.⁷ His ancestors “owned land that the America took and now calls it Texas,” he told me. He has a strong sense of national pride and honor, as well as cautiousness, about U.S. political agendas and institutions. He has learned to “never challenge authority in the United States because you can’t trust what they will do. You have to just get along and mind your own business or it’s trouble.” How do I know these things about Mr. Ortiz? It is simple—we talked. When time I picked him up to take him to the clinic for an interview session (Duffy, 2006), he spontaneously volunteered information on his family history, simply because we were conversing. This was not in the context of a probing litany of cultural questions, but merely reciprocal human interest in each other and sharing which took less than a few minutes.

Mr. Ortiz thinks the doctors are very nice, but he never challenges them, and never will. He just keeps going back, trying to try to get answers to his health problems. The clinic staff questions whether or not he even needs to be there most of the time because his presence has become so familiar. They seem to question the legitimacy of his frequent visits.

⁷ Latino, rather than Hispanic, is the preferred term to reference persons from or with origins in Mexico, Central or South America, Spain, and other countries. Demographic data collected and reported in the free clinic network broadly uses the term “Hispanic” to encompass all persons of Latino origins. In 1997, Office of Budget changed use of the term Hispanic to Hispanic or Latino when collecting census data.

They also think he is a very nice man, and they will keep seeing him as long as he wants to come.

As evidenced in his story, Mr. Ortiz is very family-oriented and places his loyalty to them above his own self-interest. This impacts his ability to advocate for himself or consider his future as an individual rather than within a family unit. He also knows that he cannot pay for health care services. How could he consider a transfer to the skilled unit when no one gave him information about how this would be paid for? He certainly wouldn't want to put his daughter's family in jeopardy of being financially liable for that kind of service.

His multiple subjectivities, not the least of which is his age, cause health care professionals and volunteers to discount him. There are a number of reasons that he accompanies his children and grandchildren to the clinic on Tuesday nights, but I have never asked him. The fact that he is there indicates he needs to be there. But other volunteers question it or find it odd. I could speculate that he truly does not feel well due to his numerous medical conditions. He could be seeking medical help from the free clinic, when in fact they are not equipped to be a medical home and all that encompasses. But he has no insurance and this is the only health care provider he knows. Even if they referred him to a regular doctor, he cannot afford it. His children are honoring their father by trying to find medical help for his health complaints and to obtain his prescription medications. The household income qualifies them for free medications with pharmacy assistance programs. They cannot afford to buy his prescription drugs, and without the clinic, he might have to go without. One could pause and wonder why he is taking over 20 medications, and if that was one source of his complaints.

Mr. Ortiz and his children may also agree that he should not stay at the house alone at night when they need to go to the clinic. This would increase his sense of isolation and loneliness. He has been there all day by himself, without transportation or social interaction. Some free clinic volunteers may have surmised that he keeps showing up again and again as a pastime. It's not very long before he doesn't seem to be taken seriously. Yet, there are probably options for him in the community to assist him and his family. With help, he could become enrolled in Medicare for health care and prescriptions, which in turn would assist him in finding a medical home. But no one at the free clinic is knowledgeable or provides that service. There are community centers and other venues for social interaction and stimulation. He cannot access them alone and his children are already stretched to the breaking point dealing with other family issues.

What happens when Mr. Ortiz's interactions with the health care providers remain at a superficial, technical level and his presence is considered commonplace and unnecessary? His therapeutic encounters become trivialized. Probably most seriously, he is possibly misdiagnosed and given treatment for an acute illness when his body is shutting down with congestive heart failure. Had his family not been available at the time his condition became an emergency, he possibly would not have received the urgent health care he needed in time. What happens when the attending physician at the hospital doesn't consider the context of his home environment and his multiple subjectivities and intersections of oppression? The outcome for the patient and his family is compromised. The physician's quick discharge decision, an administrative matter, is placed in front of taking time to understand Mr. Ortiz's decision-making needs and priorities, personal values, and unique cultural perspective.

In regards to the ultimate health outcome, Mr. Ortiz does not receive the important rehabilitation that he needs to become more functional and independent in his own home. In the long run he may never gain his optimal level of health and function because he was deprived of that opportunity. Long-term consequences of such neglect are further dependence on others and fewer years to live independently as he ages. In the aggregate, experiences like this lead to ongoing health outcomes disparities for members of racial and ethnic minorities.

Health care providers, in concert with other community resources, should look more globally at the impact they can make in the health of underserved populations. Communicating with and advocating for Mr. Ortiz does not have to be difficult or time-consuming for clinic volunteers or health care professionals. I was able to write a letter justifying his suitability for publicly subsidized senior housing in less than 10 minutes. There has to be a commitment from volunteers, medical and lay professionals, to get involved in nontraditional roles in order to provide holistic culturally sensitive patient care (Levi & Walens, 2001). There has to be an evolution in medical education to seek social remedies for underserved populations. There has to be a social justice imperative imbedded in the curriculum (Maina, 2002).

Intersectional understandings, used for clinical knowledge and pedagogically, allow students, academic faculty, and preceptors to widen their field of vision to include more than the immediate physical needs of the patient (Tucker et al., 2003). For Mr. Ortiz's family, primarily his daughter Carmen, his unexpected and unplanned discharge home from the hospital only increased the level of stress and caregiving responsibilities, all of which magnifies the symptoms of Carmen's own chronic diseases and compromises her health and well-being. The impact on family and social units is another case for using Intersectionality

Theory as a grounding theoretical framework in medical education. This pedagogical theory breaks the artificial categorizations of cultural understanding and the subsequent tendency toward reducing and defining patient as “other” in a narrow, but manageable, context (Kirkham & Anderson, 2002). Now I will proceed with additional analysis using Michelle’s story and her encounter at the free clinic.

“No one should be treated like that”

It may not seem at first glance that Michelle is a patient with any type of extraordinary needs for culturally sensitive care. She is Caucasian, articulate, and apparently more than adequately clothed, groomed, and fed. Although she is obese, her mobility and posture appear normal, and besides, her health care visit does not include chronic disease management. Consequently, the medical volunteers might conclude, even before talking to Michelle, that they will not need to spend much time with her. She is able to provide a detailed and accurate medical history and appears to be independent, self-sufficient, and relatively healthy, all things considered. When she meets with the medical students or physician she speaks directly and knowledgably. Her requests for services are unequivocal because she researches her medical conditions and has been her own advocate for a long time. Michelle understands her health status quite well compared to the majority of patients and coordinates all of her own health care, and that of her family. However, without engaging with Michelle, the health care volunteer could take the therapeutic encounter in a direction that can result in more damage than good.

Michelle’s personal history of poverty, childhood physical abuse, adult sexual abuse, and other personal and family stressors are inextricably linked to her anxiety and depression, and her symptoms of these conditions only increase when she must be in a public place

(Schachter, Stalker, & Teram, 1999). Making the trip to the free clinic is something that requires her to prepare mentally, physically, and financially. She wants to be sure that she can actually handle leaving the house, afford gas for the car, tolerate sitting in the waiting room with the other patients, and present herself appropriately to others. Although it may seem like a normal, uncomplicated “trip to the doctor” for most, it requires a great deal of emotional reserve for her to go to the free clinic, and is almost impossible for her in “regular” health care. She only goes to this free clinic location because she was able to negotiate some of the conditions of her care with Dr. Bailey. With the recruitment of more volunteers to share the volunteer service, Dr. Bailey is now only on duty one every other month. Michelle now has a history with most all of the other volunteers except the new physician whom she hadn’t met before the story shared here.

The 30ish-year-old, White, male physician is in a position of authority and dominance over Michelle and she must place her welfare in his power while she is at the clinic for this visit. The physician, without even asking any clarifying questions, prances into the treatment room to make his pronouncement about her inappropriate reasons for seeking health care at the free clinic. Perhaps he noticed her thick medical record with stickers on the front flap of the folder for each year she had been a patient, since 1998. The entire conversation and interaction with this physician are to Michelle a symbolic representation of her past history of abuse (Clark, McComas, & Potter, 1999). This conversation may be considered rude or a hassle to some others, but to Michelle her treatment was an assault on her personally, and she was unprepared for the surprise attack.

Intersectionality Theory informs my analysis of Michelle’s story and helps me to consider areas of oppression and subordination that are part of her multiple subjectivities.

Even though her race is that of the dominant culture, her gender, her physical appearance, and her mental illnesses are also intrasectional variables that contribute to her oppression relative to society, and in particular, to this physician.

In Michelle's life as a survivor of sexual abuse with concomitant psychological post-traumatic stress, she also is dealing with the fear of being widowed (deserted) by the possibility of her husband's death before her own. She does not know what she would do for family income for herself and the three year-old granddaughter she has legally adopted. Her history of sexual abuse contributes to her self-identity and self-esteem as exemplified perhaps in her obesity. The interrelatedness of her obesity and physical presentation lead to a social stigma (Goffman, 1963) associated with spoiled identity. Even though Michelle is highly intelligent, well educated and articulate, her anxiety behaviors impact her communication style and also create distance in her relationships. Just coping on a daily basis is hard enough without being "assaulted" again when she seeks health care.

In Michelle's expression of anger, she is taking her own power and identity back from the physician who exerted his dominance over her in the clinical interaction. Her ability to communicate this to me is congruent with one of Michelle's strength: self-advocacy. In her telephone call, Michelle was also communicating, "Even though this [mistreatment] happened to me, make sure this doesn't happen to anyone else." Michelle's sense of social justice and advocacy for others raises her above the circumstances of this abuse. She knows this interaction is an aberration. She knows that vulnerable patients put their trust in physicians. No one, not even a physician, has the right to assault her, under any circumstances.

Maybe the physician thought she was “freeloading” off the free clinic when she has insurance. What he does not appreciate is that she also has an expensive monthly premium and that she cannot afford the office co-payments. But he didn’t ask either. That lack of interest or desire to seek clarification is evident as we deconstruct the health care encounter using Intersectionality Theory as a basis of the understanding of Michelle’s experience.

But what do patients do when they desperately need these health care services, and there is nowhere else to go? (Weiner, 2001). They likely will subject themselves to these mistreatments in order to get the health care services they need. They will not question the physician/health care provider’s authority and power for fear of retribution. For Michelle, she will be wary the next time she needs medical care. She might even call ahead to find out who the doctor will be that night. She will make every attempt not to see this physician. Michelle has a dilemma. She has used the free clinic regularly for 10 years and doesn’t know where she will go next if this doesn’t work out. And in addition to all of that, she has to get over the trauma of her last encounter.

Intersectionality Theory and the Pedagogy of Medical Education

The connections between curriculum design, cultural competency, experiential learning and student outcomes of culturally and linguistically sensitive care require a transcendent pedagogical orientation. The pedagogical model that I propose has a theoretical grounding applicable to all health professions, and academic and clinical faculty, and it addresses the lack of a diverse workforce and the resultant manifestations of racism that lead to health outcomes disparities. This new pedagogy recognizes the contributions that Intersectionality Theory makes in recognizing the historical and present day forms of oppression of marginalized groups (Collins, 2000). This perspective then allows the student,

faculty, and professionals, interacting with patients and individuals in the context of the health care encounter, to consciously recognize the various forms of dominance and oppression that comprise a patient's multiple identities, history, and narratives, especially but not exclusively, in underserved and vulnerable populations.

However, equally as important in the application of Intersectionality Theory is to acknowledge that the analysis of oppression does not define a patient as a person, does not reduce them to a stereotype defined by these impressions. Recognizing complexity, as my analyses illustrate, reveals the unique attributes, capabilities, and identities of the patients. These are not overshadowed by the oppressive or marginalized conditions from their previous history, but perhaps sources of knowledge, wisdom, transformation, and growth. It is the complexity that requires understanding by the health care professional or student.

Clinicians who are open (attitudinal orientation) to seeing (interpreting) patients in all of these multiple subjectivities (complexity) and are reflexive (intentional learning and skill development) about the cultural encounters can reduce patient perceptions of aloofness and distance, which may be interpreted as any of a number of barriers to quality health care. Failure of the clinician to be present with a patient may be perceived as a lack of concern, disrespect, and even rejection. All of these interpretations, whether founded or not, interfere with culturally competent care.

I will now describe the application of Intersectionality Theory as a grounding for health professions education pedagogy through clinical vignettes as shared with me by two free clinic patients, Mr. Ortiz and Michelle. These are just two examples of how and why health disparities exist in the U.S. for individuals from marginalized populations. Physicians and health care providers have a position of power, dominance, and control in health care

delivery, and this must be acknowledged by the professionals. Overt communication and efforts must be taken to break down this inequality in the relationship because it may be one of the most dominant influences on the patient–professional relationship.

Quality of the educational experience depends on the role models available (Shipengrover & James, 1999). Cultural competency training for preceptors is as important as that of health professions students (*Cultural Competency Challenge*, 2005). How can it become integrated into medical education? Through joint ownership, planning, and commitment between the community-based and the academic health center (O’Toole, Kathuria, Mishra, & Schukart, 2005). Students should also evaluate the cultural competency of their preceptors and include reference to Intersectionality Theory (O’Toole et al.). These types of activities for formative and summative program evaluation need to be imbedded into existing classes, curriculum design, and agreements with community-based partners.

Application to Curriculum: Pedagogical Strategies Using Intersectionality Theory

A connection between cultural competence and experiential learning is augmented by using Intersectionality Theory. Experiential learning then moves medical education to another level of transformative learning. However, there must be institutional integration of Intersectionality Theory for there to be any organizational transformation. Administrators and curriculum designers at health professions education programs should look for opportunities in the pre-, intra-, and post-didactic phases of professional education. If health professions schools are serious about transforming graduates, faculty, and professions to reduce health care disparities, responsibilities and accountabilities must be created. The institutional culture of the university should support critical conversations on cultural competency/sensitivity if untoward incidents occur between patient and students or

preceptors. The application of the pedagogical model and strategies should include solicitation of feedback from patients.

Transforming health care professions education necessitates adoption of strategies to explicitly value cultural competency skills and knowledge (Geppert et al., 2007). Noted below are activities, initiatives, and philosophical considerations for inclusion in program administration, curriculum design, and experiential learning. These strategies are grouped according to pre-admission, didactic program, and clinical internships and residencies as follows:

Medical/Health Professions School Application Process

- Give preferential weighting to pre-requisite courses in multicultural and second language coursework in undergraduate degree program (e.g. American Sign Language or Medical Spanish for Health Professionals, etc.)
- Include questions and discussion of cultural diversity in applicant selection interviews

Academic Health Centers

- Curriculum infusion of Intersectionality Theory and health policy
- Leadership and accountability of academic and faculty regarding cultural competency curriculum infusion
- Oversight, policies and procedures for clinical sites that include accountabilities for experiential learning and ongoing interaction with preceptors
- Core curriculum includes linguistic/second language courses

- Evaluations of cultural competence with professional actors and include debriefing with peers and faculty⁸

Clinical Internship Sites

- Role models that are knowledgeable and accepting of Intersectionality Theory and reflect understanding of matrix of domination and oppression analysis
- Student and preceptor written reflection and debriefing using Intersectionality Theory
- Evaluation of preceptors by students on application of Intersectionality Theory

Conclusion

Pedagogical theories provide guidance on how to teach and facilitate student learning. In health professions education, pedagogical theories to support cultural competency training are attached to experiential learning, on a practical level, and reflexivity, on a cognitive theoretical level. Intersectionality Theory contributes to cultural competence training regardless of model, method, or clinical setting. Patients come to the health care encounter in a state of vulnerability and dependence (Bond, 1999; Bottomley, 1999; Buss, 1985; Perry, Lynam, & Anderson, 2006). The multiple subjectivities and complexities of their lives include race, class, gender, age, sexual orientation, disability/ability, and other factors that

⁸ Des Moines University, Des Moines, IA, has designed the Standardized Performance Assessment Laboratory (SPAL) for medical student learning of skills related to history taking, examination, and patient education. Medical student interactions with professional patient actors are videotaped for student debriefing and learning modules, as well as evaluation of clinical competencies. The pedagogical model would suggest that content relative to cultural competency and application of Intersectionality Theory would be imbedded in this type of model. <http://www.dmu.edu/departments/spal/experience/>; accessed April 12, 2008.

intersect and mesh to influence the overall standpoint of the patient to affect their quality of life, health, and experiences accessing health care (Jackson & Williams, 2006).

Student/faculty/preceptor transformation occurs with a change in attitudes, beliefs, and values. For individual transformation to transform health professions education, there must be a mutual understanding and acceptance of this pedagogy in the academic-community partnerships, the academic–clinical site agreements, and within each educational program. There must be mutual commitment to hold each organization and individuals within the organizations accountable to each other for consistently applying and reinforcing this theoretical framework.

The clinical vignettes presented in this article support multiple arguments for curriculum infusion of Intersectionality Theory. For example, sufficient time for patient interaction must be allowed for the appropriate interpersonal interaction. Regular health care has reduced appointment times in physician offices to a minimum because of economic pressures. Time has become a valuable and scarce commodity in health care, but is necessary for the patient–professional relationship. Once the trust and rapport are established and on firm ground, flexibility in the face-to-face communication is possible and less likely to influence health outcomes. This is an underpinning of a primary care medical team (Beal et al., 2007).⁹ Outcomes actually improve by establishing medical homes where patients are known in the context of their families and multiple subjectivities. Patients and their health are

⁹ I avoided saying primary care physician, but instead used primary care medical team to acknowledge the importance of coordination of care among all health professionals, the contributions all team members make to the quality of the clinical encounter, and the patient’s reliance on the cohesiveness and communication among team members.

viewed holistically, and the time it takes to address their unique situations is desired (Levi & Whalen, 2001).

The introduction of Intersectionality Theory does not have to be complicated or foreign to medicine and health care. Health care professionals are educated to understand the concept of “intersectionality” as it is applied in a different context, i.e., the domains of mental or physical disease used to determine health status.¹⁰ It is not difficult, then, to use that same way of thinking in the analysis of social locations of dominance and oppression. It requires acknowledgement by the health care professional, student, faculty, and preceptor that the impact of these socially constructed identities are indeed associated with and result in dominance and oppression. Perhaps feminist perspective is more accepted in nursing because of the predominance of women and the historical culture of subrogation to physicians. Now critical feminist theory empowers professional nurses to seek knowledge and use their own agency, individually and collectively.

Like the academic programs, the free clinics may think that they must accept every community partner, preceptor, internship site, or volunteer that expresses interest in serving. I challenge free clinics to solicit patient feedback and convey a set of expectations to their volunteers. Should those standards of cultural competence and communication standards be ignored or challenged, then perhaps choices indeed need to be made for the sake of the patients’ physical, mental, and emotional safety. We know the patients don’t have choices,

¹⁰ The concept of intersectionality in health care has existed in a different context in the teaching and analysis of co-morbidities. Co-morbidities in medicine and psychiatry look at the impact, relation, and influence of simultaneously occurring disease states. It is not the co-morbidities of disease states that are salient in the discussion of applying intersectionality in health care. What is salient is the “way” of thinking about conditions.

but the clinic organizers do. The philosophy of free clinic health care services “at least being better than nothing” may not hold true (Spielbauer, 2004), which Michelle and Mr. Ortiz’s experiences demonstrate so clearly.

Having a primary care physician helps reduce health care disparities, according to Politzer et al. (2001), but does not guarantee it. To answer the questions of how health professional education programs can prepare students and young professionals so they are best able to communicate with and engage patients from diverse populations in their own health care, we need only turn to the themes that are represented in the patient vignettes. By listening to patient voices, health professionals glean a rich understanding of their patients. The patients themselves tell clinicians what to pay attention to through their narratives. In some corners of health care and health professions education there may exist the implicit message that cultural and linguistic competency is optional or comes second to technical proficiency. I will continue to ask “Why?” Is it really possible to provide quality health care without listening to their voices?

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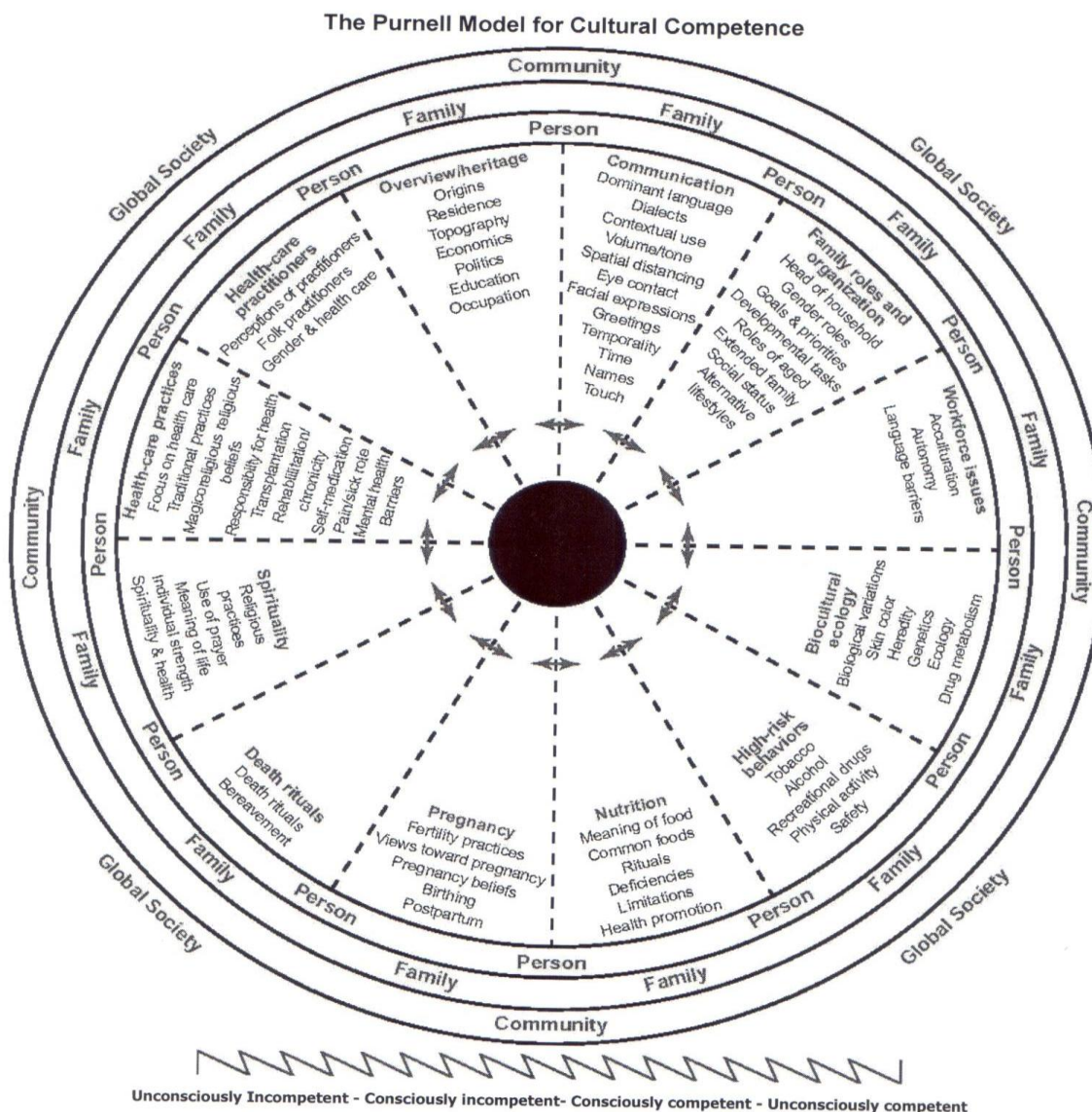
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Appendix: Purnell's Model of Cultural Competence



Primary characteristics of culture: age, generation, nationality, race, color, gender, religion

Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

Unconsciously incompetent: not being aware that one is lacking knowledge about another culture

Consciously incompetent: being aware that one is lacking knowledge about another culture

Consciously competent: learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions

Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures

CHAPTER 5 GENERAL CONCLUSIONS AND REFLECTION

A discussion of free clinics cannot occur without noting that for the patients receiving services the regular health care system has failed them. The current health care system fails to provide health care for individuals and families in seven distinct categories: (a) the unemployed; (b) those who have retired and are not yet eligible for Medicare; (c) transition period between jobs; (d) part-time employees, even if they are working more than one job; (e) employees in small businesses that don't offer health insurance; (f) employees who cannot afford the employee share of health insurance not covered by their employer; and (g) those in this country illegally (Weiss, 2006, pp. 58-61). For these individuals and their dependents, the free clinics and clinic systems throughout the United States offer health care that they would otherwise not get. The participants and free clinic structure reported in this ethnography are not unlike others in the local free clinic network or around the country that find that there continues to be large unmet need for health care (Jacobson, Dalton, Berson-Grand, & Weisman, 2005; Weiss, 2006).

The free clinic volunteers share a common value that the care they provide should not only be of high quality, but also performed in such a way as to preserve and enhance the dignity of all patients who receive health care from them. In the midst of treating 20 or more patients on any given Tuesday night, they, too, are observing that the demands on them are different than they were 10 years ago when the clinic opened.

Changing Focus from Primary Care to Chronic Care Management

The traditional role of free clinics to improve access to medical services is changing from a focus on acute primary care for the indigent and homeless to providing health care for

the working poor and individuals with chronic conditions. When the free clinic opened 10 years ago, the incidence of care for chronic conditions was rare, whereas now it is more than 10.7% (see chapter 3, Table 7). In the past year, the clinic volunteers and network staff have reported a dramatic increase in patients who return for follow-up visits for chronic conditions and prescription drugs, functioning as a medical home for some. This is consistent with previous studies that have demonstrated patients who continue to use free clinics for more than one year often do so to obtain prescription drugs and to have a regular source of health care (Keis, DeGeus, Cashman, & Savageau, 2004).

Patients' needs for medical homes strain the health care safety net to the breaking point. Free clinics do their best to provide prescription drugs and basic health care but cannot provide all diagnostic and therapeutic services nor manage chronic disease. The volunteers are to be commended for their commitment and dedication to the patients and the mission of the free clinic. In addition to health care, patients have other significant social needs. The free clinics would benefit their patients even more if there was a greater understanding of how patients can obtain other services in the immediate region.

Contributor to the Underground Economy

The health care safety net, which in the past included local hospitals, is suffering from various nationwide economic pressures. Recently hospitals, traditional safety net providers, have taken hard line stances to strictly limit the amount of charity care they will provide in a year (Wolfskill, 2005). As a result, the free clinic networks are stretched to the breaking point with increasing demand and inability to refer patients with more complex medical needs to local hospitals as they were able to do in the past. The end result is patients do without health care entirely.

The free clinic network makes an estimated annual contribution to the state economy of nearly \$1 million, which includes direct patient care in the form of volunteer in-kind service as well as medical supplies and prescription drugs (Gray, 2007). This type of economic contribution is not lost on the state policymakers who, for the second year in a row, are providing a state subsidy for free clinics. Patients who seek care at a free clinic do not require state help through Medicaid programs. In another words, free clinics are good for the state budget (Freking, 2005). If one considers the aggregate contribution free clinics make as part of the underground economy, free clinics in the U.S. are subsidizing the health care system to the tune of at least \$1 billion annually (Weiss, 2006). According to the National Association of Free Clinics (2005), the contribution is over \$3 billion annually. This does not even take into account the avoided costs of emergency room visits and the treatment of more chronic diseases that would otherwise require emergency care if not treated early at the free clinic. This analysis prompts several questions: Are free clinics part of the solution or part of the problem? Does the substantial contribution made by free clinics further enable a dysfunctional health care system? Does the growing number of free clinics make it easier for federal policy makers, whether elected or appointed, to ignore the needs of the uninsured?

Insurers continue to advocate private industry solutions over government plans for health care reform. The Blue Cross and Blue Shield Association proposals are not without merit but represent long-term philosophical shifts that do not address the current environment. Initiatives to improve quality standards, provide incentives for prevention and wellness in health insurance benefit design, and provide consumer driven coverage do not meet the needs of the working poor and other marginalized people who come to the free clinic at the present time (*The Pathway to Covering America*, 2008). Reliance on these long-

term strategies is only likely to increase the number of uninsured in the short run as cost shifting to employees continues unabated in our employer-based model. Consequently, more free clinics continue to sprout up around the country in church basements, community centers, and other non-profit entities (Duara, 2008; Geller, Taylor, & Scott, 2004).

Institutional Barriers at Every Level

Loosely organized, the free clinic network member clinics try to address their various issues as they arise individually. The clinics are autonomous and prefer it that way. As a member of the board of directors, I suggested that the statewide network sponsor adult education to teach volunteers medical Spanish, which would assist them in their work with the growing Hispanic population. The idea was briefly discussed and dropped for lack of interest by others with uncertainty as to whether this was the role of the network or a priority for the network central administration. By most reports, the growing number of Hispanic patients is evident at each of the clinics. Institutional barriers abound, even in the academic health centers.

Two third-year medical students (MS3), J.D. and Elliott, reported, “The [academic program] list of courses has an elective of “Medical Spanish” but we are so loaded down with other courses that very few people, other MS3s, sign up for it.” Some of the barriers to taking the class are the way the classes are organized within the school of medicine. “It was only offered in the evening, and it was hard to fit it in with all the other classes, labs, and studying. I took it, and personally think that it should be a required course so that we can better communicate with the patients,” J.D. said. Elliott agreed and said that all the clinics she has been to in the community medicine rotation have the same problem with language barriers. The ability of the health care practitioner to communicate with patients in their

preferred language is so basic to the relationship that academic programs should consider this as relevant to preparing students (Masin & Tischenko, 2007; Purnell & Paulanka, 2005). This ability to communicate enhances the patient–professional relationship and facilitates transformational learning (Masin & Tischenko) as well.

Another area where free clinics could make a difference for patients is assisting in enrolling eligible patients in Medicare, Medicaid, and the SCHIPs government health insurance programs. Although this seems like an obvious solution to both managing the high volume of patients coming to free clinics and connecting the patients to a source of comprehensive medical care, there are real barriers to implementing this type of additional service. The free clinics in the area were surveyed and responses from the clinic managers identified barriers to this additional role, including the opinion that this was outside the scope of their mission, they lacked knowledgeable and trained volunteers, and there is no available space and time within clinic hours to perform the new process.¹

Free clinics have real limitations in what they can provide for patients as stop-gap providers of health care. Volunteer staff rotate through the free clinic every four to six weeks and do not meet together to discuss their work otherwise. However, students can collaborate with and be active in partnering with volunteer staff to locate and document the availability and other community agencies and social services for patients and their families. Safety net

¹ Most free clinics are only open a few hours per week with a volunteer staff that rotates frequently, sometimes weekly. Thus, without significant volunteer training, structural changes, and defined processes, improving the continuity of follow-up medical services, enrollment in PAPs, or other services such as enrollment into Medicare and Medicaid, it is nearly impossible for the free clinics to undertake this new responsibility of connecting patients to established government insurance programs.

providers and community-based providers are often recruited to serve as clinical rotation internship sites. Academic medical centers and other health professions education programs should work closely with community partners to be sure that quality health care is delivered to patients and that the student's participation is commensurate with their level of education and training (Buchanan & Witlen, 2006). But for these settings to truly be opportunities for transformative learning, the experiential learning must intentionally include reflection, consideration of cultural competence and diversity, and preceptors who can integrate these concepts as well as serve as role models for students.

“I Just Needed to Hear Your Voice”

As a feminist researcher, I entered this field work indeed open to the possibilities of building relationships with participants and with patients in the free clinic who were not directly involved in the study. At times, the relationships became both puzzling and stressful for me. This was unexpected. One of the participants seemed to struggle with relationship boundaries and in the first interview revealed the entire history of her childhood sexual abuse from her father. This was an emotional interview and from that moment forward, I became part of her support system. This involved daily phone calls as well as gifts and cards that she would bring to the clinic on Tuesday nights or mail to my home. At times I felt uneasiness that she seemed to have a greater need for this friendship than I needed or was comfortable providing. I had concerns that any withdrawal of my availability might lead to her emotional breakdown and worsening of her psychological state.

My own reflection tells me that my steadfastness and presence to listen and reassure helped get her through many tough times. As she told me, “I was someone she could just talk to.” The dialogic nature of our relationship was acknowledged to be helpful to her in finding

her own strength and courage to go on day to day. Sometimes it was looking for a job, taking her medication, keeping contact with her family, and keeping her job in spite of many stressors. I decided early on not to take responsibility for her happiness but instead to be someone that she could count on for the truth and a sense of stability.

In reflecting on the reciprocal qualities of the participant–researcher relationship in my field work, I did share personal history and stories and opened myself up to some vulnerabilities. Health professionals are used to asking the questions, not necessarily sharing. This is very different than what is conveyed in health professions programs where courses in patient–professional boundaries teach the clinician to maintain neutrality and objectivity, not get involved with patients. I believe my nonjudgmental validation of patient stories, friendly interactions, and dialogue helped in building trust and establishing rapport with each participant. Keeping an artificial distance seems unreasonable.

I still maintain informal contact with many of the study participants. They all wanted to help me with my research, and they wanted to tell their story and share their perspective. There was genuine revealing of personal information. That was humbling for me, and I felt privileged to be witness to what they were telling me. I agreed to be someone with whom their stories and feelings were safe. I continue to volunteer and see the participants from time to time since the formal conclusion to the interviews and focus group. Because everyone at the clinic knows each other on a first name basis, I have taken extra care to have conversations with these participants in private as much as possible to convey to them that our relationship and the information that they shared with me is not public information.

On the continuum of stranger to friend, I became part of the support network for some patients—one in particular was even suicidal and my role was to be a listener, a supporter, a

sounding board, a reality check; someone who could provide even-handed advice. I had to consciously try not to be one of her health professionals but instead someone she could rely on when she was unsure of herself and needed positive support. When she was questioning the usefulness of her employee assistance program counselor, I mentioned a possible alternative and gave her a phone number. Ultimately she decided against my recommendation. She said, “I didn’t want to do it—see him—if the only reason was that I thought you wanted me to see him. I had to make a decision if this was right for me. I decided that it wasn’t.” In the end, I was reassured that she was able to make a rational decision based on her own instincts and assessment. We discussed her decision, and she also accepted that I was not disappointed but, rather, understood and respected that the decision about who to seek for counseling was a very personal decision and hers to make. It was this type of interaction, focusing on issues of importance to the participants and identification with their individual circumstances that I believe did indeed enhance my own abilities to interpret the interview data (Bloom, 1998).

During one of the interviews, when I asked about the diversity of patients at the free clinic, Michelle speculated that some patients might be bothered by the “Christian overtones” at the community center. “It’s pretty obvious at the community center here with the religious things that are laying out for their church services.” She was not offended by these artifacts and expression of faith, but was concerned that other patients who were not from a Christian background would be uncomfortable. The work of the free clinics is obviously aligned with the work of social, religious, and community organizations to “serve those in need.” However, Michelle raised a good point. The bigger question in federal policy debate is this: To what extent is the administration willing to turn over health care for marginalized people

to faith-based groups to subsidize the federal budget? Is this only a loosely veiled effort at proselytizing the Christian message of forgiveness and redemption to the poor and downtrodden? Is this not just another way of providing a portal into Christianity?

On the Horizon

Perhaps there is some hope that academic medicine will change. A new field is emerging in medical practice to encourage patient life stories and narratives. The purpose of such inquiry is to engage physicians in the patient's perspective and experience with their doctors and the health care system. The participant data reinforces the needed emphasis on a holistic approach to patients and their health care, especially for individuals from marginalized groups. *Patient Listening: A Doctor's Guide* (Herlwaldt, 2008) is the most recent publication exhorting physicians and health care providers to listen to patient stories to glean the power of their message and gain an understanding of the verbalized and unsaid communication. Herlwaldt also supports the importance of including qualitative and interpretive research methodologies and methods in the creation of knowledge in medicine for physicians. This is another voice pointing to the myopia of an exclusive positivist orientation to health care delivery as embodied in the culture of medicine and health care delivery. One might even say the positivist orientation obstructs the true view of a patient in the most basic sense. I will continue to work within the system at health professions academic programs, on the free clinic network board of directors, and at the health insurance company to do what I can to teach from this perspective, to be an advocate for patients, and be a catalyst for change within the health care industry. I owe a debt of gratitude to all the patients I have met during my research and volunteer service at the free clinic. They have educated me.

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