“OF THE POOR, BY THE POOR, OR FOR THE POOR”:
COMMUNITY HEALTH CENTERS AND THE WAR ON POVERTY

By

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activists graciously agreed to talk with me, and some even welcomed me into their homes. Speaking with them added an invaluable dimension to my dissertation research. I was deeply inspired by their deep, abiding belief that “health care is a human right” and their commitment to putting that principle into practice.

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INTRODUCTION

In his 1964 State of the Union address, President Lyndon Johnson launched an offensive against poverty in the United States, declaring, "Our aim is not only to relieve the symptom of poverty, but to cure it and, above all, to prevent it." Invoking the language of disease and sickness, Johnson echoed many of his contemporaries in suggesting that poverty was an illness plaguing an otherwise robust American society—a disease that could be defeated, or "cured," if only the American people would marshal their resources and rally behind the cause. A heady optimism infused this inauguration of the War on Poverty. Just as American medicine was opening new frontiers in its battles against disease, so too might the government solve long-standing social ills such as poverty. Poverty and disease—once considered regrettable realities—now appeared to be problems that Americans could fight, even conquer.

For many Americans, however, this connection between poverty and health may have resonated on a deeper level. By the mid-1960s, the links between poverty and health were clearer than ever before. Physicians and scholars alike had begun to talk about a "health gap," pointing out that poor Americans were much more likely to suffer from illness than their better-off counterparts were.[1] The concept of health itself was also undergoing a transformation. In 1948, the World Health Organization (WHO) had adopted a new definition of health, one unprecedented in its breadth: "Health is a state of complete physical, mental, and social well-being, and not merely the absence of infirmity."[2] By the 1960s, the WHO definition enjoyed

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[1] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century,* eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 14-15.

[2] World Health Organization (WHO), "WHO Definition of Health," 1948, <http://www.who.int/about/definition/en/print.html>

wide acceptance among professionals and experts. Their optimism buoyed by the advances of the civil rights movement, medical reformers believed that a more equitable health care system was within reach.[3]

With change seemingly on the horizon, reform-minded professionals and experts began to put forward their alternative visions for the future of American health care, testing new ways of extending health care to the poorest citizens. Some of these visions drew on a field that was just recently gaining popularity in medical schools—community medicine. Though the idea of community had a long history in American health policy, community medicine as a separate field only emerged in medical schools in the late 1950s.[4] These community medicine departments focused on the entire community, rather than the individual patient, as the unit of study and proclaimed the importance of rooting out environmental causes of some of the most common diseases.[5] By the mid-1960s, a new, more radical strain of community medicine vitalized the field, pushing the issue into the center of national politics.

Community medicine of the 1960s was a diverse field with fluid boundaries, but it had an immediate appeal to reformers searching for a better way of reaching the poor. The War on Poverty renewed interest in community-based solutions, and policy makers in Washington extolled "community action" as a way of improving the status of the poor. In fact, the Office of Economic Opportunity (OEO), the agency in charge of directing most War on Poverty programs, argued

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[3] Victor W. Sidel and Ruth Sidel, "Introduction," in *Reforming Medicine: Lessons of the Last Quarter Century*, ed. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 3.

[4] For example, during the Progressive era, community control of hospitals had become a major issue, with Progressive reformers fighting to replace control by local elites with professional control. For more on the history of "community" in health policy, see Mark Schlesinger, "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy," *Journal of Health Politics, Policy and Law* 22, no. 4 (1997): 937-992.

[5] Kurt W. Deuschle and Frederick Eberson, "Community Medicine Comes of Age." *Academic Medicine* 43, no. 12 (1968): 1229.

that community action was the key to the "quiet revolution" that would bring an end to poverty by "offer[ing] self-help as a substitute for welfare, and participation as a substitute for acceptance."[6] Medical reformers proposing community-based solutions found policymakers receptive to their ideas and ready to fund demonstration projects. By the mid-1960s, "community" was the buzzword of medical reformers and federal policymakers alike. These two paths converged in 1965, when the newly formed OEO funded the community health center program, a community-based experiment in health care delivery.

This dissertation explores the intersection of ideas and policy. In his intellectual history of the Progressive Era, *Atlantic Crossings*, the historian Daniel Rodgers argues that the Great Depression, like other major crises, generated an "opportunism of expediency." That is, as policymakers scrambled for solutions, they turned to the policy ideas of the previous generation of Progressive reformers.[7] Taking its cue from Rodgers, my dissertation argues that, like the early 1930s, the War on Poverty provided the political impetus necessary to turn "old" ideas into new social policy.

In 1964, Jack Geiger, a doctor with a long history of civil rights activism, was searching for funding for his plan to bring modern medical care to the poor by establishing community health centers. Geiger had spent the early 1960s working for the Medical Committee for Human Rights (MCHR), an organization of medical professionals committed to aiding civil rights activists.[8] In December 1964, he and other members of that organization's executive committee were

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[6] The Office of Economic Opportunity During the Administration of President Lyndon B. Johnson, November 1963-January 1969, Volume I—Administrative History, 2. Lyndon Baines Johnson Library.

[7] Daniel Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge: The Belknap Press of Harvard University Press, 1998), 414.

[8] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 45.

discussing the possibility of setting up health care centers for the poor. Dissatisfied with the results of efforts funded by private philanthropy, Geiger remembered his four-month trip to South Africa ten years before, where he had observed health centers that had been established by Drs. Sidney and Emily Kark in the 1940s. These centers, developed to treat African and Indian populations suffering from extreme poverty, had pioneered the concept of community-oriented primary care, an approach that sought to improve the health of the entire community by addressing environmental factors, including sanitation.[9]

Geiger was convinced that the poorest regions of the U.S. could also benefit from this model of community-oriented primary care. Teaming with Count Gibson, the chair of the new Preventative and Community Medicine Department at Tufts Medical School, he approached the surgeon general's office in the Department of Health, Education, and Welfare (HEW) in January 1965 with his proposal. HEW directed him to the OEO, an agency signed into existence in August 1964 that was searching for proposals to fund. The community focus of Geiger's plan made it a good fit for the new agency. Geiger approached the OEO with a proposal to fund a $30,000 "feasibility study" for a community health center in the rural South; the OEO countered with $300,000 to fund the entire project. With these additional funds, Geiger and Gibson planned a second health center – an urban center to serve residents of a public housing development in Columbia Point, Boston.[10] Soon, OEO increased the budget to $1.3 million. In June 1965, the OEO officially approved a grant to Tufts Medical School for a health center at

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[9] Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," 17.
[10] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick: Rutgers University Press, 2007), 8.

Columbia Point and another at an unspecified rural southern site, which was later located in Mound Bayou, Mississippi.[11]

As Geiger and Gibson began work on Columbia Point, similar proposals began to materialize across the country. Shortly after the Watts riots of 1965, the University of Southern California's medical school received OEO funding to set up a community health center in the center of Watts.[12] In Chicago, the Chicago Health Research Foundation teamed up with the Presbyterian-St. Luke's Hospital, a teaching hospital affiliated with the University of Illinois, to establish a health center on the west side of the city.[13] In New York City in July 1966, Montefiore Hospital in the Bronx received $1.9 million to establish a Neighborhood Medical Care Demonstration, later known as the Martin Luther King Jr. Health Center.[14] Just a month later, the OEO approved a grant to the Denver Department of Health and Hospitals to establish the Eastside Neighborhood Health Center.[15]

The OEO designated these centers "research and demonstration" programs until November 1966, when a congressional mandate sponsored by Senator Edward Kennedy established a Comprehensive Health Services Program within the OEO. In 1967, HEW joined

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[11] Bonnie Lefkowitz, *Community Health Centers*, 8-9.

[12] "Doctors: Miracle in Charcoal Alley," *Time*, November 1967; Box 6, Folder "CAP Los Angeles Sept-Dec 1967"; Inspection Reports, 1964-1967, Office of Economic Opportunity, RG 381, National Archives at College Park, College Park, MD.

[13] Joyce C. Lashof, "The Health Care Team in the Mile Square Area, Chicago," *Bulletin of the New York Academy of Medicine* 44, no. 11 (1968): 1363.

[14] Harold B. Wise, "Montefiore Hospital Neighborhood Medical Care Demonstration: A Case Study," *The Milbank Memorial Fund Quarterly* (1968): 297.

[15] David L. Cowen, "Denver's Neighborhood Health Program," *Public Health Reports* 84, no. 12 (1969): 1027.

the community health effort, funding an additional 50 centers.[16] By 1974, over 800 community health centers had been established, and 70 percent of their clients were poor.[17]

The neighborhood health center movement offered an alternative to the traditional hospital model of health care delivery. While the hospital model focused on the individual sick patient, community-based alternatives placed illness within a larger environmental context, treating all residents in a particular geographic area as potential patients.[18] Although all community health centers had a central clinic staffed with physicians providing ambulatory care, their services also extended beyond the clinic walls. Staff at the Tufts-Delta Health Center in Mound Bayou, for instance, dug wells and drainage ditches and built privies out of abandoned buildings. After discovering that most of the community suffered from severe nutritional deficiencies, staff members stocked the center's pharmacy with food and issued prescriptions. Eventually, hoping to establish a longer-term solution, community organizers at the health center worked with the community to set up a cooperative farm on unused land.[19] Similarly, the health center at Columbia Point led a campaign to eradicate rats and roaches from its affiliated housing development. Community health centers thus engaged in constant experimentation. Adopting a more comprehensive vision of health, they tested innovative methods of health care delivery in order to meet the unique needs of marginalized populations.

In his landmark book, *The Social Transformation of American Medicine,* Paul Starr argues that clinical medicine and public health diverged at the beginning of the twentieth

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[16] Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," 19.
[17] Jennifer Nelson, "'Hold Your Head Up and Stick Out Your Chin': Community Health and Women's Health in Mound Bayou, Mississippi," *NWSA Journal* 17, no. 1 (2005): 100.
[18] Bonnie Lefkowitz, *Community Health Centers*, 7.
[19] Jack Geiger, "The Tufts-Delta Health Center: A Progress Report," October 1968, pg. 68, Box 20, Folder 7, Subject Files 1885-1994, Tufts School of Medicine Records, 1882-1994, Tufts University Library.

century. While clinical medicine dealt with the treatment and curing of illness, it left prevention largely to public health experts, who trained in separate schools. The result was the "artificial separation of diagnosis from treatment" that relegated public health to "secondary status," outside the bounds of "mainstream medicine." After the 1930s, as clinical medicine grew in prestige, the realm of public health shrank, focusing on only the most routine tasks.[20]

Community medicine was, in many ways, an attempt to reconcile the schism between the two disciplines. The founders of community health centers proclaimed the benefits of a more "comprehensive" approach, but in many ways their vision drew on solutions that had long been considered the domain of public health. Thus, community health centers were radical not because they invented new solutions, but because they creatively fused long-standing ideas from different disciplines, creating a new sort of institution in the process. In the name of comprehensive health care, community health centers compelled medical professionals to re-envision their own roles. Writing about this adjustment, Geiger stated, "For a long time, health professionals, in medicine, or nursing, or social work, chose—or pretended—to deal with illness, not with its roots in the social order; with the diagnosis and treatment of disease, not with the relationships between disease and the social, biological, and physical environment, and certainly not the economic or political environment." The concept of community health centers forced open this narrow understanding of professional roles. Its supporters demanded that health professionals combine preventative and curative measures—or, as Geiger phrased it, treat the "rat" as well as the "rat bite."[21]

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[20] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 196-197.

[21] Jack Geiger, "Hidden Professional Roles: The Physician as Reactionary," reprinted from *Social Policy*, March/April 1971, Box 48, Folder 360, Delta Health Center Records, The Southern Historical Collection, The University of North Carolina at Chapel Hill.

In linking the medical and the social, community medicine was only the latest iteration of a much longer tradition. Social medicine, or the "idea of medicine as a social science," had roots in nineteenth-century Germany, when proponents of medical reform such as Rudolf Virchow and Salomon Neumann posited that, since health was connected to social and economic factors, society had a responsibility to address the health of its members.[22] Later, in the interwar United States, movements to restore the study of the "patient as a person" arose in reaction to the perceived depersonalization of scientific medicine.[23] At Johns Hopkins, for example, chair pro tem George Canby Robinson worked to expand the medical schools' involvement in the "social sphere" by encouraging the collaboration of physicians and social services personnel on "health teams."[24] Similarly, the dean of Yale's medical school, Milton Winternitz, pushed to integrate the medical school with the larger graduate school, arguing that medicine should concern itself with "man's entire social and economic environment."[25] These efforts spawned imitators, with American medical schools across the country developing departments of "preventative medicine" and "comprehensive care."[26] The postwar period intensified these efforts. As specialization and fragmentation threatened the traditional medical school model, physicians turned increasingly to "comprehensive care" to act as a corrective.

When community medicine first surfaced in the United States in the late 1950s, it seemed little more than a minor digression from the mainstream. A small number of physicians,

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[22] George Rosen, "Approaches to a Concept of Social Medicine. A Historical Survey," *The Milbank Memorial Fund Quarterly* 26, no. 1 (1948): 7.

[23] Theodore M. Brown, "George Canby Robinson and 'The Patient as a Person," in *Greater than the Parts: Holism in Biomedicine, 1920-1950*. eds. Christopher Lawrence and George Weisz (New York: Oxford University Press, 1998), 135.

[24] Brown, 140.

[25] Arthur J. Viseltear, "Milton C. Winternitz and the Yale Institute of Human Relations: A Brief Chapter in the History of Social Medicine," *The Yale Journal of Biology and Medicine* 57, no. 6 (1984): 875.

[26] Brown, "George Canby Robinson," 152.

struggling to deal with recent changes to the medical school model, turned to the study of the "community." Rather than focus on the impact of individual behavior, these physicians made the community their central unit of study, arguing that the health of individuals could not be properly addressed without understanding the disease patterns of their communities. The early days of community medicine were marked by considerable intellectual murkiness. Health care practitioners deployed the term to denote an amalgam of preventative medicine, public health, and comprehensive care, but the boundaries of the field remained largely porous. Perhaps aided by these ambiguities, community medicine quickly became a buzzword among medical educators, though it formed the basis for very little tangible reform.

Little more than a footnote during the 1950s, community medicine exploded onto the national stage in the 1960s. The Civil Rights Movement and the War on Poverty had shifted the political calculus, and programs that promised to deal with poverty through community-based solutions were suddenly in vogue among federal policymakers. The political shift made room for a new set of reformers. Physicians such as Geiger, inspired by the Civil Rights Movement, helped establish a community health center program that was far more comprehensive and far-reaching than the programs of the late 1950s. The idea of "community"—used before in a more limited, epidemiological sense—was suddenly reinvigorated. Rather than just treat "community" as the unit of study, Geiger and like-minded physicians envisioned health centers that would, through mechanisms of "community control," empower local leaders. This emphasis on community control resonated with the OEO's focus on community action, propelling the community health center movement into the center of the War on Poverty. Thus, the manifold connotations of "community" made it a convenient locus for the intersection of the medical and the political. Its very ambiguity allowed it to become a repository for all sorts of political goals.

Liberal and radical physicians, political reformers, and medical schools all hoped that the community health centers could advance their own objectives.

Medical schools, for example, played a major, but often fraught, role in the neighborhood health center movement. During 1965 and 1966, 50 percent of OEO health center grants went to hospitals, 37 percent to medical schools, and 13 percent to health departments.[27] In fact, these figures likely understate the involvement of medical schools. Hospitals that sponsored health centers often had strong affiliations with local medical schools, which provided much of the staff support and training. Medical schools were in many ways perfectly positioned to operate the centers; after all, they had provided the institutional home to community medicine departments in the late 1950s and early 1960s. Not only were medical schools one of the few institutions with the expertise and resources to support health centers, but their students could also benefit from the training and research opportunities the health centers provided.

This symbiotic relationship did not last long, however. Though departments of community medicine championed the integration of medicine and public health, they rarely collaborated with schools of public health in their community health efforts and thus never truly eliminated the long-standing schism between the two disciplines.[28] Furthermore, medical schools, health care reformers, local community groups, and OEO bureaucrats often clashed, revealing conflicting definitions of "community." Although some medical schools provided an institutional home to Geiger and like-minded physicians, the schools were first and foremost professionalizing institutions, and their interests often differed from the OEO's emphasis on community control. While OEO officials had initially entered into agreements with medical

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[27] Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," 19.

[28] F. Douglas Scutchfield, J. Lloyd Michener, and Stephen B. Thacker, "Are We There Yet?: Seizing the Moment to Integrate Medicine and Public Health," *American Journal of Preventive Medicine* 42, no. 6 (2012): S98.

schools enthusiastically, they soon came to reconsider the outsized role they had given to professionals.

Despite attempts to involve the "community," tensions between professional authority and community control roiled the new health centers. In 1968, Lisbeth Bamberger and Joseph English, who headed the OEO's health division, wrote of their initial decisions to favor medical schools with regret: "We did not fully appreciate that the requirement of full participation by those being served after a proposal had been approved could never make up for the fact that the project had been originated and formulated by professionals alone."[29] By the early 1970s, the OEO changed its policies in an effort to transfer additional control to community members. In 1971, only 7 percent of OEO grants went to medical schools and 10 percent to hospitals. In contrast, 59 percent went to new health corporations that had stricter requirements for community participation.[30] After this shift, medical schools no longer held direct responsibility for the health centers, although they often remained affiliated with them and continued to supply them with resources, staff, and professional expertise.

The community health center program was the result of interactions between federal officials, medical reformers, medical schools, health radicals, and the patients themselves. Drawn together by the appeal of "community," these groups soon realized that their interests did not always align. This dissertation explores these tensions and conflicts, shedding light on how the competing definitions of "community" shaped the implementation of the community health center program. To do so, this dissertation eschews both "top-down" and "bottom-up" approaches in favor of a more integrated perspective that reveals a more complex dynamic.

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[29] Lisbeth Bamberger Schorr and Joseph T. English, "Background, Context and Significant Issues in Neighborhood Health Center Programs," *The Milbank Memorial Fund Quarterly* 46, no. 3 (July 1, 1968): 292.
[30] Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," 19-20.

Few works have dealt with the history of the community health center program, and the ones that have generally view the program through a narrow lens. Alice Sardell's 1988 book, *The U.S. Experiment in Social Medicine*, remains the most thorough treatment of the community health center program, but, as a political scientist, Sardell is primarily interested in the “policy networks” that created and sustained the program. Focusing on these policy processes, Sardell concentrates on a small group of elite actors and neglects the dynamics on the ground.[31] Bonnie Lefkowitz’s *Community Health Centers: A Movement and the People Who Made It Happen*, takes a very different approach. Relying almost exclusively on oral history and interviews, Lefkowitz provides a detailed look at the internal operations of a handful of community health centers but does little to contextualize the program within the War on Poverty.[32] More recently, a few excellent studies of individual health centers have emerged, most notably Thomas Ward’s 2017 *Out in the Rural*, a history of the health center in Mound Bayou, Mississippi.[33] These accounts have provided invaluable perspective and shed light on little-known actors in the community health center program, but rarely do they combine this work with a similarly critical analysis of the federal government and social policy.

Not only do studies of community health centers rarely incorporate nuanced analyses of the War on Poverty, but the literature on the War on Poverty also largely neglects the health centers. Even so, War on Poverty historiography has suffered from similar divisions as the work on community health centers. Early assessments of the War on Poverty, for example, tended to present the War on Poverty as a series of top-down initiatives, focusing on Johnson and a handful

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[31] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986* (Pittsburgh: University of Pittsburgh Press, 1989).

[32] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick, NJ: Rutgers University Press, 2007).

[33] Thomas J. Ward Jr., *Out in the Rural: A Mississippi Health Center and its War on Poverty* (New York: Oxford University Press, 2017).

of advisers. These histories generally adopted the same starting point—failure. On both the left and the right sides of the political spectrum, scholars in the 1970s and 1980s tended to assume that the story of the War on Poverty was one of failed promises, and their work attempted to explain the problems that plagued it. Those on the left, for instance, critiqued the programs for not going far enough, arguing that the policies failed because they focused on the rehabilitation of individuals, rather than on altering the more fundamental structural causes of poverty. Those on the right, too, believed the War on Poverty had been flawed, but for very different reasons. For conservatives, the War on Poverty was an exercise in federal waste that resulted not in the eradication of poverty but in a surge of welfare dependency.[34]

Recent scholarship, however, has undertaken a reappraisal of the War on Poverty, examining its successes as well as its limits. Michael Katz, who issued a new edition of his 1989 book, *The Undeserving Poor,* in 2013, attributed much of this shift to a changing political context. In the 1970s and even 1980s, he argued, the mood of progressives was still optimistic. Although Johnson's reforms had been beaten back by a conservative movement, poverty remained a live issue. By the 1990s and 2000s, however, the mood had shifted. As conservative discourse became hegemonic, poverty seemed to fade from public debate altogether. Historians studying the War on Poverty began to ask different questions. Suddenly, the War on Poverty seemed optimistic—a moment of possibility rather than one of failure.[35]

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[34] Frances Fox Piven and Richard A. Cloward, *Regulating the Poor: The Functions of Public Welfare* (New York: Vintage, 1971); Michael B. Katz, *The Undeserving Poor: From the War on Poverty to the War on Welfare* (New York: Pantheon Books, 1989); Allen J. Matusow, *The Unraveling of America: A History of Liberalism in the 1960s* (New York: Harper & Row, 1984); James T. Patterson, *America's Struggle Against Poverty, 1900-1980* (Cambridge: Harvard University Press 1981); Daniel Patrick Moynihan, *Maximum Feasible Misunderstanding: Community Action and the War on Poverty* (New York: Free Press, 1969).

[35] Michael B. Katz, "On Rewriting *The Undeserving Poor*," *Berfrois,* October 2, 2013.

This shift in focus was accompanied by a shift in perspective. As they looked past the usual stories of failure, a new generation of scholars argued that the War on Poverty had found more success at the local level. In a plethora of case studies that focused on individual programs and individual cities, these scholars presented the War on Poverty not as a series of reforms produced by top-level government officials, but as a grassroots social movement. In the introduction for her 2011 book, *The War on Poverty: A New Grassroots History (1964-1980)*, Annelise Orleck wrote, “Poor people across the nation mobilized in the name of participatory democracy and greater community control.”[36] The War on Poverty may never have succeeded in achieving its promises, these historians argued, but it had galvanized local community activists.[37]

This dissertation attempts to reconcile the split between the bottom up and the top down while also integrating the community health centers into the larger history of the War on Poverty. Not only does it delve into the on-the-ground dynamics of individual health centers, it also treats the federal government’s War on Poverty apparatus as more than just a homogeneous block. For example, it looks closely at the specific individuals within the OEO who were charged with administering the community health center programs. These officials often acted as liaisons between the health centers and the government. Understanding their interactions with the reformers who ran these centers, then, is crucial to understanding both the community health

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[36] Annelise Orleck, “Introduction: The War on Poverty from the Grassroots Up,” in *The War on Poverty: A New Grassroots History, 1964-1980*, eds. Annelise Orleck and Lisa Gayle Hazirjian (Athens, GA: University of Georgia Press, 2011), 2.

[37] Annelise Orleck and Lisa Gayle Hazirjian, eds., *The War on Poverty: A New Grassroots History, 1964-1980* (Athens, GA: University of Georgia Press, 2011); Annelise Orleck, *Storming Caesar’s Palace: How Black Mothers Fought Their Own War on Poverty* (Boston: Beacon Press, 2005); Susan Youngblood Ashmore, *Carry It On: The War on Poverty and the Civil Rights Movement in Alabama, 1964-1972* (Athens: University of Georgia Press, 2008); Robert Bauman, *Race and the War on Poverty: From Watts to East L.A.* (Norman, OK: University of Oklahoma Press, 2008); John Dittmer, *Local People: The Struggle for Civil Rights in Mississippi* (Urbana: University of Illinois Press, 1994).

center program and the way in which the complex negotiations between elite actors and the grassroots shaped War on Poverty policy.

The history of community health centers also has a great deal to offer the scholarship on the welfare state. Historians of welfare policy have argued that the New Deal put in place a two-tiered welfare system, dividing universal benefits like social insurance from targeted public assistance. Under this system, universal programs like Social Security, which were understood as "rights," won widespread acclaim. Programs targeted at marginalized groups, on the other hand, faced much more criticism, depicted disparagingly as "welfare."[38]

The community health center program fits uneasily within this system. Though the program was developed as a way to bring health care to the poor (i.e., a targeted population), its advocates were never entirely comfortable with this designation. They strenuously fought off labels of "poor people's medicine" and combated efforts to institute means testing. Many, in fact, harbored more radical hopes and treated community health centers as a model of health care for all Americans.

In a 1967 article titled "Of the Poor, By the Poor, or For the Poor: The Mental Health Implications of Social Control of Poverty Programs," Jack Geiger asked,

> Shall there be programs *for* the poor, in the classic public welfare sense? Shall there be programs *by* the poor, involving [in that wonderfully nebulous phrase] 'maximum feasible participation' of the target population in the implementation of programs, in the acquisition of new jobs, in consultative or advisory roles that give (or seem to give) a share in decision-making, policy-making, choice, and management? Or shall there be programs *of* the poor, implying not merely

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[38] Michael B. Katz, *The Undeserving Poor: America's Enduring Confrontation with Poverty* (Oxford: Oxford University Press, 2013); Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America*: New York: Basic Books, 1996). Linda Gordon, *Pitied But Not Entitled: Single Mothers and the Origins of Welfare, 1890-1935* (New York: The Free Press, 1994); Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (New York: Oxford University Press, 1994); Mary Poole, *The Segregated Origins of Social Security: African Americans and the Welfare State* (Chapel Hill: University of North Carolina Press, 2006).

> participation but control and power—the real social power that comes from choice of programs and from control of money and jobs.[39]

These questions highlight not only the tensions that surrounded the community health care model but also the challenges this model posed to the welfare state. Geiger, like many other advocates of the community health center program, sought to overhaul the relationship between the poor and the welfare system, moving the poor from a place of "passive receptivity" to one of "power."[40]

As this dissertation will show, these efforts to subvert the two-tiered welfare system faced intense opposition and were, for the most part, beaten back, first by Congress and later by the Nixon administration. Still, the history of the community health center program sheds light on the more radical possibilities of the War on Poverty and highlights a brief moment when the two-tiered welfare state did not appear inevitable. In tracing the rise and fall of the community health center's radical promise, this dissertation explores tensions and conflicts that lay beneath the surface of the welfare state.

Finally, the history of the community health center program offers a new perspective on the history of health care reform in the United States. Like historians of the War on Poverty, historians of health care reform have focused on failure. These historians have generally sought to understand why, as Jill Quadagno subtitled her book, "the U.S. has no national health insurance."[41]

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[39] H. Jack Geiger, "Of the Poor, By the Poor, or For the Poor: The Mental Health Implications of the Social Control of Poverty Programs," *Psychiatric Research Reports* 21 (1967), 55.

[40] H. Jack Geiger, "Of the Poor, By the Poor, or For the Poor," 55.

[41] Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005); Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge: Cambridge University Press, 2002).

Such questions, premised on a version of American exceptionalism, have proven to be fruitful ones, providing important springboards for comparative studies. At the same time, however, by focusing on failure, these historians have often overlooked moments of possibility. In a 2003 article for the *American Journal of Public Health*, for example, the historian Beatrix Hoffman wrote that health care reform failed in the United States because there was never a grassroots movement for change. While many groups demanded change, she argued, these groups acted separately: "Many grassroots movements, including the civil rights and women's movements and those on behalf of people with particular diseases like AIDS, have demanded changes in the health care system. But their health care demands were for specific changes on behalf of their particular group, such as racial desegregation of hospitals, access to abortion, and the release of experimental AIDS drugs."[42]

Hoffman's assertion is not a unique one. Many historians, in fact, have lamented the lack of collective action for health care reform.[43] The past two decades, however, have witnessed a renewal of interest in the intersection of social movements and health care reform. Rather than despair of the failure of grassroots action, these historians have begun to seriously engage with radical health movements, uncovering their contributions and analyzing their critiques of the American health care system. The historian Naomi Rogers, for example, has explored the previously understudied history of the Student Health Organizations (SHO), a student health

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[42] Beatrix Hoffman, "Health Care Reform and Social Movements in the United States," *American Journal of Public Health* 93, no. 1 (2003): 75.

[43] Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005); Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America* (Baltimore: Johns Hopkins University Press, 2005).

movement that called for a radical overhaul of the nation's health care system.[44] From John Dittmer's study of the civil rights movement and health activism, to Alondra Nelson's work on the Black Panthers' free clinic program, to Jennifer Nelson's history of the feminist women's health movement, historians have begun to push back against attempts to marginalize radical health movements, arguing that these groups voiced robust critiques of the health care system that extended far beyond "specific changes on behalf of their particular group."[45]

Like these recent works, this dissertation moves the radical critiques of American health care from the margins to the center of study. It looks at why "community health" appealed to many of those who believed that health care could be an "instrument for social change" and how critiques of the American health care system were able to converge to form the basis of a federal program. It argues that, though the community health center program did not transform the country's health care in the way that many of its more radical advocates had hoped, the movement left an indelible mark on American health policy.

Through these chapters, I lay out the history of the community health center program and trace the ever-evolving definitions of community, community health, community action, and community control. Chapter One begins by examining the first programs to adopt the label "community medicine" in the 1950s. It argues that medical schools developed community medicine departments as a reaction to postwar changes in American medical education. As medical schools became increasingly specialized and fragmented, community medicine seemed

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[44] Naomi Rogers, "'Caution: The AMA May Be Dangerous to Your Health': The Student Health Organizations (SHO) and American Medicine, 1965-1970," *Radical History Review* 80 (2001): 5-34.

[45] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*. New York: Bloomsbury Press, 2009); Alondra Nelson, *Body and Soul: The Black Panther and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 58; Jennifer Nelson, *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015).

to promise integration. This chapter looks closely at a few of these early programs, namely Dr. Walsh McDermott's efforts to improve health care on the Navajo reservation in the early 1950s and Dr. Kurt Deuschle's community medicine department at the University of Kentucky in the late 1950s and early 1960s. In the process, it seeks to understand what these early adopters meant when they said "community medicine."

Chapter Two shifts the focus, moving from this handful of medical educators to the health activism of the early 1960s. It argues that the civil rights movements of the early 1960s invigorated the field of community health. A new generation of physicians, seeking to unite their professional expertise with activism, experimented with innovative ways to use health care as a tool in their fight for social justice. In particular, this chapter examines the MCHR and its involvement in the fight for civil rights in Mississippi. Ideas about community participation in health care arose as these health professionals became involved in providing direct care to Mississippi residents during Freedom Summer. These ideas, having emerged on the ground in Mississippi, then came together in the model of the community health care center that Dr. Jack Geiger presented to Tufts University.

Chapter Three explores how the community health center model became the basis for a federal social program. It posits that much of the model's early success can be attributed to good timing. As Geiger and his fellow MCHR members were exploring ways to connect community to health care, the OEO was searching for community-based solutions to poverty. Thus, when Geiger presented the "community health center" model and requested funding, the OEO not only was happy to oblige, but also encouraged other medical schools to submit similar proposals. Soon, community health centers, which appeared to merge the fundamental tenets of "community health" with "community action," were cropping up across the country. This chapter interrogates both of these terms and lays out the central tenets of the emerging model.

If Chapter Three shows how different groups were able to unite over the shared appeal of community-based solutions, Chapter Four uncovers the confusion over the ambiguous definitions of "community" and "community control." "Community control" had seemed promising in theory, but its implementation proved difficult. By the late 1960s, community health centers were experiencing both internal and external pressures. Internal power struggles, for example, plagued the centers, making it difficult to pinpoint a single, coherent "community." At the same time, a growing radical health movement placed new demands on "community control," imbuing it with new connotations of self-determination. Amidst this ferment, the OEO was growing increasingly disillusioned with medical schools as possible vectors for social change.

In Chapter Five, these tensions come to a head. This chapter charts the major changes in the community health center program in the early 1970s. By the end of the 1960s, the OEO, dissatisfied with the role of medical schools, was moving to give grants directly to community-run governing boards. While in some ways this transfer can be read as a success of community control, it occurred at a time when the Nixon administration's opposition to War on Poverty reforms was undermining the very foundation of the community health center model. The fiscal austerity of the early 1970s, for example, threatened the most radical of the health centers' innovations. This chapter explores this paradox, looking closely at the health center in Mound Bayou, Mississippi, to understand how these changes in policy shaped the centers on the ground.

Finally, the conclusion follows the community health center model from the 1970s to President Barack Obama's Affordable Care Act. It argues that the more radical dreams for community health faded over time. For example, the efforts of radical health activists in the 1970s to expand the promise of community health from a narrow group of the poor to all citizens were never able to get off the ground. At the same time, community health centers, after enduring a period of fiscal austerity and budget cuts, were able to recover and thrive, though their radical edges had long since dulled.

There are two histories here. On the one hand, this dissertation follows the history of community health centers—the people who ran them and the populations they served. On the other, it follows the history of the idea of community health—what its advocates believed that it could be. This dissertation shows how these histories intersected, overlapped, and, eventually, diverged.

CHAPTER 1

Experiments in Community Medicine:

Medical Schools in the 1950s

In 1956, as the University of Kentucky was planning to open its medical school, the dean, William R. Willard, issued a statement that laid out the philosophy of the new school. Written in conjunction with a group of planners from diverse professional backgrounds such as sociology, statistics, medicine, and economics, the statement emphasized the school's close connection with its surrounding community: "To know the health problems of the area, some members of the faculty must study them. … To accomplish this, the community must be utilized as a laboratory in which the medical school studies certain problems just as the hospital ward or physiology laboratory must be utilized for the study of other problems."[46] Willard's philosophy presented an innovative relationship between the medical school and the community. This relationship was firmly grounded in reciprocity. In order to treat members of the surrounding community, Willard suggested, the medical school would first have to study them. While the community would benefit from the services offered by the medical school, the researchers and students at the school would gain access to an unprecedented "laboratory" for their studies.

Such an arrangement between the community and the medical school proved groundbreaking. When the University of Kentucky College of Medicine opened its doors in 1960, it established a department of community medicine, the first of its kind in the country. Under the direction of Dr. Kurt Deuschle, the program blended epidemiology and field work, pioneering an innovative approach to health. The model that Deuschle developed at Kentucky

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[46] Kurt W. Deuschle, Hugh S. Fulmer, M. J. McNamara, and Jesse W. Tapp, "The Kentucky Experiment in Community Medicine." *The Milbank Memorial Fund Quarterly* (1966): 9.

established a precedent that other medical schools soon emulated, and by the mid-1960s, departments of community medicine were cropping up in medical schools across the country.

Later generations of health reformers would call Deuschle the “father of community medicine,” but he did not invent the field out of nothing. By the mid-1950s, community medicine had already become a buzzword among American medical schools, though few of those who invoked it would have been able to articulate a precise definition. This chapter argues that interest in community medicine was both a product of and a reaction to the postwar era. As hospitals and medical school underwent a massive transformation in the 1950s, physicians and medical educators, worried that they were losing sight of the “total health” of the patient, experimented with alternative methods of health care delivery. Many of these physicians turned to “community” as a way of combating the increasing fragmentation of medical care.

An Era of Experimentation

The postwar period transformed American medical schools. World War II had forged an alliance between medical schools and the federal government, as medical schools’ contributions to the war effort had convinced both legislators and the American public that the interests of medical schools were aligned with the national welfare. Cold War dynamics strengthened this collaboration. Again, the federal government called on medical schools to act in the national interest, placing its faith in medicine and science to drive American international leadership. As Paul Starr noted in his *Social Transformation of American Medicine*, science became a “national asset,” that was “vital to national security.”[47] J. Edgar Hoover, writing a guest editorial in the Journal of the American Medical Association, urged doctors to join the fight against

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[47] Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York, Basic Books, 1982), 335.

Communism, employing an extended metaphor suggesting it was doctors' responsibility to "keep America healthy" by "kill[ing] these Communist germs."[48]

Indeed, medical advancements seemed to back up this faith. Even the skeptical could see the tangible achievements that modern medicine was producing. As one medical research report noted, "Penicillin and the sulfonamides, the insecticide DDT, better vaccines, and improved hygienic measures have all but conquered yellow fever, dysentery, typhus, tetanus, pneumonia, meningitis. Malaria has been controlled. Disability from venereal disease has been radically reduced by new methods of treatment. Dramatic progress in surgery has been increased availability of blood plasma."[49] By the early 1950s, it did not seem naive to believe that medicine could soon conquer disease.

Thus, over the next two decades, the federal government funneled massive amounts of money into science and higher education. From 1940 to 1960, federal support of higher education increased 100-fold, reaching $1.5 billion in 1960.[50] Much of this money went to medical schools, which suddenly found themselves flush with funds for research. Cornell, for instance, had spent $170,000 on research in 1939. Just eleven years later, the medical school was managing a research budget of $1,153,000. This trend was mirrored nationwide. From 1940-41 to 1950-51, research spending at public schools increased by 900%, while spending at private schools increased by over 700%.[51]

As medical research changed in scale, it also transformed in character. In his history of American medical schools, Kenneth Ludmerer notes that medical research in the postwar era was

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[48] John Edgar Hoover, "Let's Keep America Healthy: A Guest Editorial," *Journal of the American Medical Association* 144, no. 13 (1950): 1094,1095.

[49] Paul Starr, *The Social Transformation of American Medicine*, 335.

[50] Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to Managed Care* (New York: Oxford University Press, 1999), 140.

[51] Kenneth M. Ludmerer, *Time to Heal*, 140.

significantly more “reductionist” than it had been a decade earlier. As the molecular revolution transformed biologists’ understanding of the cell, medical researchers abandoned the traditional observational approach to research and focused instead on the subcellular and molecular levels. With the lines between medical and biological research blurred, researchers coined the term “biomedical” to describe the intersection of the two fields, which seemed to present an exciting new frontier.[52]

As medical research grew more complex, medical schools responded by becoming increasingly specialized. Specialization in medicine had been on the rise since Flexner’s report, issued in 1910, had called for a more scientific approach to medicine, but the trend accelerated rapidly in the postwar era. As medical knowledge expanded, individual mastery of an entire field became impossible. Instead, more medical students chose to specialize, training to become experts in increasingly narrow areas of medicine. The place this change was most visible was in medical residency programs. Once an option available to those interested in pursuing an academic path, residency was “democratized” in the 1950s, becoming the rule rather than the exception.[53] By the 1960s, internal medicine, once a fairly cohesive field, could be split into ten or more subdivisions.[54]

Medical research was not the only force driving the rising prominence of medical schools and teaching hospitals in the postwar period. At the same time, their clinical role was growing rapidly. In the prewar period, hospitals had served a limited population of mostly charity patients. These patients, known as “ward” patients, served vital functions in the medical school system. By following their cases, medical students learned about the course and treatment of

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[52] Kenneth M. Ludmerer, *Time to Heal*, 148-49.
[53] Kenneth M. Ludmerer, *Time to Heal*, 181-82.
[54] Kenneth M. Ludmerer, *Time to Heal*, 150.

disease. This continuous care was considered crucial to medical education. Only by following a case in its entirety, educators believed, could medical students comprehend the various stages of disease. Similarly, ward patients played an important role in medical research, providing a population for clinical observation. Ward patients, then, formed the bedrock of the prewar teaching hospital, uniting the hospital's missions of service, education, and research.[55]

By the 1940s, however, the role of ward patients had begun to erode. As health insurance became more popular, newly insured middle-class Americans began to seek health care from teaching hospitals, now considered synonymous with high-quality medical care. This rising demand transformed the teaching hospital. Not only did the proportion of ward patients shrink drastically, but the growing number of patients, combined with the complexity of the new, specialized medical procedures, meant that the hospitals became busier and more hectic. To accommodate these patients, the length of the average hospital stay plummeted.[56] These clinical changes had significant implications for the nature of medical education and research. Insured patients, for instance, were much less willing to welcome medical student or resident involvement in their cases. Meanwhile, the shrinking length of hospital stays seemed to undermine the continuity considered necessary for medical education and research, as neither students nor researchers could follow a disease from start to finish.[57]

Enjoying unprecedented levels of national recognition, funding, and patient populations, medical schools in the 1950s appeared to be experiencing a "golden era." At the same time, however, some educators were beginning to worry that these swift changes were undermining the traditional pillars of medical education and research. Concerned that specialization in

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[55] Kenneth M. Ludmerer, *Time to Heal*, 176.
[56] Kenneth M. Ludmerer, *Time to Heal*, 176.
[57] Kenneth M. Ludmerer, *Time to Heal*, 175-176.

medicine had gone too far and had become too narrow and technical, these educators and researchers experimented with different approaches to temper scientific medicine with a focus on the "total health" of the patient. Though never the mainstream, these efforts nevertheless attracted a number of reform-minded physicians, producing what the physician McGehee Harvey later called an "unprecedented period of reappraisal and experimentation" in medical schools.[58]

Comprehensive Care

The first of these experiments were aimed at reforming medical education. In the postwar period, the medical school curriculum evolved to reflect the recent changes in medical research. As research shifted from a clinical observational approach to a biomedical one, the curriculum for medical students adapted to incorporate more of the basic sciences. New courses like pathophysiology, for example, focused on the biological processes underlying disease.[59] As the curriculum developed, however, the approach met backlash from some educators and students, who charged that the increased focus on scientific foundations had come at the cost of the social and economic context of medicine.[60]

At medical schools across the country, educational reformers experimented with various ways to teach medical students to understand the patient as a whole person, rather than as an amalgamation of biological and chemical processes. These programs, which adopted the name "comprehensive care," included a variety of different approaches, but all focused on establishing long-term relationships between students and patients.

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[58] A. McGehee Harvey and Susan L. Abrams, *"For the Welfare of Mankind": The Commonwealth Fund and American Medicine* (Baltimore: Johns Hopkins University Press, 1986), 218.
[59] Kenneth M. Ludmerer, *Time to Heal*, 198.
[60] Kenneth M. Ludmerer, *Time to Heal*, 198.

Medical educators found an enthusiastic ally in private foundations. Private foundations had a long history of funding scientific research, but by the 1940s growing federal spending on science and medicine was beginning to dwarf these private contributions. In 1947, for instance, private foundations provided $10 million in funding for scientific research in medicine, while the federal government provided $100 million. In order to make a more significant impact, private foundations sought to carve out new niches for themselves.[61]

The Commonwealth Fund, for example, had historically funded scientific medical research, but in the late 1940s, it turned instead to medical education. Comprehensive care immediately attracted the Fund's interest. A new but growing field, comprehensive care seemed to be a perfect opportunity for the Fund to maximize its impact and differentiate itself in crowded field. At the same time, like educators in medical schools, many at the Fund were frustrated by what seemed to be the fragmentation of medical education. One high-ranking staff member reported, "Increasingly we had come to view health and disease in a holistic frame of reference in which the psychological, social, and cultural aspects of human behavior are appropriately related to the biological nature of man and the physical environment in which he lives."[62] Comprehensive care, then, promised to unite all these fragmented pieces into a cohesive whole. Under the direction of Daniel Sheehan, a former professor of anatomy at NYU School of Medicine, the Fund collaborated with medical schools to establish comprehensive care programs across the country.

The first—and most prominent—comprehensive care program emerged at Cornell University Medical College. Cornell already had close ties to the Commonwealth Fund. In 1946, David P. Barr, the chairman of the Department of Medicine at Cornell, had joined the

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[61] A. McGehee Harvey and Susan L. Abrams, *"For the Welfare of Mankind,"* 207.
[62] A. McGehee Harvey and Susan L. Abrams, "*For the Welfare of Mankind*," 224.

Commonwealth Fund, becoming the first physician to serve on its board of directors. Like Sheehan, Barr was drawn to comprehensive care and encouraged the Fund to support these experiments in medical education. Thus, when George Reader, a physician at Cornell, brought his idea for a comprehensive care clinic to the Commonwealth Fund, it won the Fund's immediate approval.

In 1952, after two years of planning, the Comprehensive Care and Teaching Program opened at Cornell Medical College under the supervision of George Reader. Like other advocates of comprehensive medicine, Reader hoped that the program would act as a corrective to an overly scientific, fragmented approach to medical care. "Medical students today," he wrote, "rarely see patients as individuals but rather as demonstrations of disease entities or examples of disordered parts of the anatomy."[63] In order to achieve this goal, Reader designed a system of continuous, outpatient care. Students involved in the program would be assigned one to three families, most of whom included at least one member with "an illness requiring continuous medical supervision."[64] For five months, these students would follow these patients' cases, making regular home visits. In the process, these students would work alongside nurses and social workers, as well as with consultants from different medical fields, such as pediatrics, obstetrics/gynecology, and psychiatry. The coordination between these different professions and disciplines, Reader hoped, would provide a "cohesive and integrating force" that would give students insight into "patient management."[65]

Just a year later, physicians at the University of Colorado were implementing a similar program, also with support from the Commonwealth Fund. Under Fred Kern, a physician at the

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[63] George G. Reader, "Organization and Development of a Comprehensive Care Program," *American Journal of Public Health and the Nation's Health* 44, no. 6 (1954): 760.
[64] George G. Reader, "Organization and Development of a Comprehensive Care Program," 761.
[65] George G. Reader, "Organization and Development of a Comprehensive Care Program," 764.

University of Colorado who had worked closely with Reader at Cornell, the medical school established the General Medical Clinic (GMC), a comprehensive care clinic at Denver General Hospital.[66] As with Cornell's program, medical students at Colorado were expected to work in the clinic for a six-month period. The GMC also emphasized continuous care and employed interdisciplinary health care teams consisting of medical students, nurses, social workers, pediatricians, and psychiatrists.[67]

The model pioneered at Cornell and Colorado was quickly imitated at Temple University School of Medicine and North Carolina School of Medicine, but within a short time, the comprehensive care movement fizzled. Critics charged that the movement was "anti-intellectual and unscientific."[68] In a 1964 article titled "General Practice in the United States," a physician at the University of Vermont College of Medicine wrote that the comprehensive care movement had amounted to little more than "a sort of 'be kind to patients' movement whose objectives were rarely explicitly defined, because they were unrelated to any adequate understanding of medical practice in the real world."[69] Indeed, there was some substance to these claims. While advocates of comprehensive care had been very clear in describing what comprehensive care was *not*, they were decidedly less clear in explaining what it *was*.

By the end of the 1950s, even the advocates of comprehensive care had noticeably cooled on its prospects. At both Colorado and Cornell, student evaluations revealed dissatisfaction with the program. Skeptical faculty also proved to be an obstacle. As Reader later noted, faculty

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[66] George G. Reader and Rosemary Soave, "Comprehensive Care Revisited," *The Milbank Memorial Fund Quarterly: Health and Society* (1976): 394.

[67] Kenneth R. Hammond and Fred Kern, "Teaching Comprehensive Medical Care," *The American Journal of the Medical Sciences* 240, no. 2 (1960): 15-16.

[68] A. McGehee Harvey and Susan L. Abrams, *"For the Welfare of Mankind,"* 224.

[69] Kerr L. White, "General Practice in the United States," *Academic Medicine* 39, no. 4 (1964): 341.

members at Cornell held “a constellation of attitudes represented by a lack of interest in some patients, desire to refer out those patients with social and psychiatric problems, and doubt that students gain anything from working with patients on their own.”[70] Without the support of students or faculty, these experiments in comprehensive care floundered. The program at Colorado closed in 1960, partly as a result of a financial dispute between the hospital and the city.[71] Cornell’s program continued until 1966, when the curriculum underwent another revision, turning the fourth year into an elective period. Though comprehensive care remained as an elective, “only an occasional student chose it.”[72]

While only a handful of medical schools had adopted full comprehensive care programs, many others had incorporated the values of comprehensive care into their own missions. According to a 1965 survey, over a dozen other medical schools had created programs “closely related in objectives.”[73] In 1952, with the support of the Commonwealth Fund, Western Reserve University School of Medicine (later Case Western Reserve University) introduced a major overhaul of its medical school curriculum. Though it did not implement a formal comprehensive care program, the Western Reserve program echoed many of comprehensive care’s core principles. Like the programs in comprehensive care, the Western Reserve program pushed back against the fragmentation of medical school education.[74] However, while the programs at Cornell and Colorado had been six-month supplements to the traditional medical curriculum, Western Reserve completely revamped the entire four-year curriculum. Traditional programs

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[70] George G. Reader and Rosemary Soave, “Comprehensive Care Revisited,” 398.
[71] George G. Reader and Rosemary Soave, “Comprehensive Care Revisited,” 395.
[72] George G. Reader and Rosemary Soave, “Comprehensive Care Revisited,” 397.
[73] William G. Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York: Oxford University Press, 1987), 308-09.
[74] Joseph T. Wearn, “Western Reserve: Background and Philosophy of Experiment,” *Academic Medicine* 31, no. 8 (1956): 516-518.

had devoted the first two years to basic sciences and the second two to clinical experience. Western Reserve challenged this separation, pioneering an integrated curriculum that used interdepartmental teaching to fuse the preclinical and the clinical.[75] Western Reserve's program was also far more successful than its counterparts at Cornell and Colorado. With much more support from faculty, the new curriculum stayed in place for decades. By the early 1980s, 18 medical schools had adopted this "organ-based model" of medical education, and one-third of medical schools were estimated to have adopted at least some elements of the Western Reserve model.[76]

At the same time that medical educators were experimenting with comprehensive care, a separate but parallel string of experiments was underway, motivated by many of the same ideals. These programs, which came to be called "community medicine," were, like comprehensive care, a reaction to the increasing fragmentation and specialization within medical schools and teaching hospitals. However, though there was considerable overlap between comprehensive care and community medicine, the focus of each was different. While comprehensive care emerged from a movement to reform medical education, those who first used the term "community" were medical researchers seeking new ways to understand health and disease within a broader social context. Comprehensive care tended to focus on individual doctor-patient relationships and the doctor's ability to see the "whole patient." Community medicine, however, attempted to rethink the relationships between doctors and the whole population they

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[75] Patricia L. Kendall and George G. Reader, "Innovations in Medical Education of the 1950s Contrasted with Those of the 1970s and 1980s," *Journal of Health and Social Behavior* 29, no. 4 (1988): 285-86.

[76] Jane S. Takeuchi, Nina M. Smith, and Allyn M. Mortimer, "Innovative Models of Medical Education in the United States Today: An Overview with Implications for Curriculum and Program Evaluation," in *Medical Education and Societal Needs: A Planning Report for the Health Professions* (Washington, D.C.: National Academy Press, 1983), 117.

served. Thus, in some ways, the advocates of community medicine pushed the principles of comprehensive medicine to their natural conclusion. If physicians needed to understand the social environment of the patient to treat illness, was it possible for doctors to treat the social environment itself?

The Navajo-Cornell Field Health Research Project

The first "community" programs did not originally label themselves as such. Instead, a shared definition of the term "community medicine" emerged only in practice, gradually evolving during the 1950s. Many of the principles that came to define community medicine first emerged in the Navajo-Cornell Field Health Research Project, a program designed to improve health care at the Navajo Indian Reservation (now, the Navajo Nation).

Cornell first became involved with Navajo health issues in 1952, when an epidemic of infectious hepatitis broke out at the Bureau of Indian Affairs Boarding School at Tuba City, Arizona, a city on the western edge of the Navajo reservation. The Bureau approached the Department of Public Health and Preventative Medicine at Cornell University Medical College, which had conducted research on hepatitis, and requested its assistance. Acting as consultants, a team led by Dr. Walsh McDermott, the head of the Division of Infectious Diseases at Cornell-New York Hospital, worked to stop the epidemic.[77] In the process, the doctors at Cornell discovered that the health problems on the Navajo reservation went far beyond hepatitis.

Tuberculosis seemed to present a particularly intractable problem. During their time in Tuba City, the Cornell team came into contact with a small hospital that cared for patients suffering from acute tuberculosis. McDermott and his colleagues immediately sensed an

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[77] Robert W. Young, "Foreword," in John Adair, Kurt W. Deuschle, and Clifford R. Barnett, *The People's Health: Anthropology and Medicine in a Navajo Community*, 2nd ed. (Albuquerque: University of New Mexico Press, 1988), xi.

opportunity. Dr. McDermott had spent the past ten years experimenting with various antimicrobial agents, and, for the past three months, he and his team at Cornell had been trying to set up trials for a new tuberculosis drug, isoniazid. In 1951, McDermott had become aware that multiple pharmaceutical companies were interested in setting up trials for isoniazid but were struggling to find suitable test patients. In order to test the efficacy of the drug, McDermott needed to find patients who had not previously been treated with streptomycin, the leading antibiotic treatment at the time. However, because of the proliferation of antibiotics in previous years, few such patients existed in New York City.[78]

The Navajo reservation seemed to present an ideal test case. When the Cornell team arrived at the Navajo reservation, they found what they perceived to be an "economically undeveloped" community, largely isolated from modern society. The Navajo reservation covered 23,574 square miles, stretching from northeastern Arizona to New Mexico and parts of Utah. However, much of the land was difficult to access. Set upon a high plateau, the area was largely secluded. Furthermore, most of the individual homes were spread far apart. Neighbors often lived several miles from each other, and the roads that connected the dwellings were frequently unpaved.[79] Geographic factors and a lack of infrastructure limited access to health care facilities.

The doctors also noted seemingly high rates of tuberculosis infection, although exact numbers proved elusive. Due to spotty recordkeeping, there were few statistics on mortality

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[78] For a more extensive account of McDermott and the history of isoniazid, see David S. Jones, "The Health Care Experiments at Many Farms: The Navajo, Tuberculosis, and the Limits of Modern Medicine, 1952-1962," *Bulletin of the History of Medicine* 76, no. 4 (2002): 758.

[79] Walsh McDermott, Kurt Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, "Introducing Modern Medicine in a Navajo Community, Reprinted from Science," January 22-29, 1960, Vol. 131, Nos. 3395 & 3396, pg. 4. Folder 3, Box 10. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

rates. In fact, because many Navajo did not report births and deaths to local authorities, even population numbers were just estimates. McDermott theorized that the high tuberculosis rates were exacerbated by the living conditions. Most Navajo lived in one-room "hogans"—log-and-mud structures with six to eight sides, a dirt floor, and no windows.[80] In order to retain warmth during the near-frigid winters, the Navajo carefully sealed all cracks in the log walls, conserving heat at the expense of ventilation. Tuberculosis, McDermott stated, thrived in such an environment: "If a single person discharging tubercle bacilli gets into such a room it can act like a transfer cabinet in a bacteriology lab."[81] The Indian Medical Service, under the direction of the Bureau of Indian Affairs (BIA), was unable to handle the problem, since the number of active tubercular cases greatly outnumbered the number of available hospital beds, and shortages of streptomycin were common.[82] Furthermore, streptomycin required daily injections to be effective, but the BIA did not have the resources to effectively distribute daily doses across such a large, sparsely settled area.[83] While the BIA attempted to remedy the situation by making arrangements with sanatoria in nearby states, many Navajo were reluctant to be isolated for the long periods required for treatment.[84] The Navajo thus presented a situation in which the typical methods of treating tuberculosis seemed to be failing.

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[80] Walsh McDermott, Kurt Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, "Introducing Modern Medicine in a Navajo Community," 4.

[81] Jane K. Zaidi, "Transcript of interview with Walsh McDermott." March 1, 1972. Folder 5, Box 11. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[82] "Dr. Walsh McDermott: 'A Man for All Seasons,'" *Cornell University Medical College Alumni Quarterly*, 42, no. 1 (1977), Folder 2, Box 7, Department of Community Medicine Records, Mount Sinai Archives.

[83] David S. Jones, "The Health Care Experiments at Many Farms," 763.

[84] Robert W. Young, "Foreword," in *The People's Health: Anthropology and Medicine in a Navajo Community*, ed. John Adair, Kurt W. Deuschle, and Clifford R. Barnett, 2nd ed. (Albuquerque: University of New Mexico Press, 1988), xii.

McDermott later recalled in an interview, “We were looking for an ethnic situation in which we could test the drug and that provided exactly that situation.”[85] To the Cornell team, the marginalization of the Navajo population made it a more attractive laboratory for research. The inadequacy of the typical methods allowed McDermott and his colleagues to overcome any ethical qualms they may have held about asking patients to forgo a tried-and-true method (streptomycin) and try instead an untested but promising alternative (isoniazid). As David S. Jones points out in his study of the Navajo-Cornell Field Health Research Project, this selection of a marginalized group as a test case was not a unique incident. “Historians have examined many similar cases of researchers utilizing marginalized, ethnic populations for medical research,” Jones wrote, “In each case, the unusually high burden of disease provided the justification for research that the researchers believed might have been ethically difficult among the general population.”[86] Sensing an opportunity, McDermott made arrangements with the BIA to begin trials.

Early trials of isoniazid on a few Navajo children were successful, and by March 1952, McDermott was meeting with the Navajo Tribal Council to discuss expanding the program.[87] Gaining the approval of the Council was essential to McDermott’s plans. Through the use of interpreters, McDermott asked the 74-person Tribal Council to allocate $10,000 of Tribal funds

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[85] Jane K. Zaidi, “Transcript of interview with Walsh McDermott.”

[86] As Jones points out, the practice of selecting marginalized groups for medical practice has had varied consequences: “The extent to which the research subjects suffered from the research has varied tremendously.” More extreme examples, such as the Tuskegee Syphilis Study, show the potentially devastating consequences of the practice. Though isoniazid ultimately proved safe and effective (and is still a leading therapy for tuberculosis today), the selection of the Navajo reservation for this trial certainly raises numerous questions about ethics in medical research. See David S. Jones, “The Health Care Experiments at Many Farms,” 764. For more on the ethics of medical research, see David J. Rothman, “The Shame of Medical Research,” *New York Review of Books*, 30 November 2000, pp. 60–64.

[87] David S. Jones notes that, within weeks, isoniazid had saved the lives of several Navajo children. David S. Jones, “The Health Care Experiments at Many Farms,” 765.

to Cornell University Medical College.[88] Although $10,000 was a mere fraction of the project's budget, the grant had symbolic value. McDermott believed such community cooperation was necessary due to the cultural gulf that separated the doctors and the Navajo. In order for this difference to be bridged, McDermott suggested, the community would need to be an enthusiastic and active participant in the project.[89] He later stated, "It was clearly understood both by the recipients and the donor that without this reaffirmation of the project, it would have to be discontinued." In the same 1970 document, McDermott added, "The community had effective instruments of control both on the local scene, and through its legislative body."[90] Cornell's effort to work with the Navajo Tribal Council and gain their cooperation—and their recognition that such cooperation would be necessary if any health project was to be effective—represents a significant effort on behalf of a medical school to coordinate with local leaders in order to provide health services to the community.

In April 1952, the Navajo Tribal Council unanimously approved the tuberculosis research program, and McDermott would continue to meet with the Council annually to renew the project.[91] Later that year, the project quickly expanded when McDermott and his colleague Dr. Carl Muschenheim partnered with Dr. Kurt Deuschle, a young physician who had been working for the Public Health Service at a tuberculosis hospital in Fort Defiance, Arizona, since

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[88] "Excerpt Taken from Minutes of Navajo Tribal Council Meeting," April 25, 1952, Folder 7, Box 11. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[89] In a later oral history, McDermott stated, "It would have been virtually impossible to work in the center of a culture so different from our own if the people had indicated they didn't want it." Jane K. Zaidi, "Transcript of interview with Walsh McDermott."

[90] Walsh McDermott, Kurt W. Deuschle, and Clifford R. Barnett, "Technologic Misfit Between a Modern Health Care System and the Demographic/Disease Pattern of Rural Poverty: The Navajo-Cornell Community Center at Many Farms," August 17, 1970, Folder 3, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[91] David S. Jones, "The Health Care Experiments at Many Farms," 765.

completing his fellowship in oncology at the State University of New York's Upstate Medical Center.[92] This partnership allowed the doctors to use the full set of resources at the hospital's disposal.[93] Overall, the local Navajo leadership and the Cornell team worked together well. As isoniazid proved an effective treatment and word of mouth spread, the doctors gained a positive reputation among the Navajo population.[94] The result was a mutually beneficial relationship, in which the Navajo community received much-needed treatment for tuberculosis and Cornell doctors were able to pioneer research on the efficacy of isoniazid.[95]

Three years later, the project took a groundbreaking turn. While the BIA had previously shouldered most of the responsibility of dealing with issues of Native American health, in 1955, this responsibility was transferred to the Division of Indian Health of the United States Public Health Service (PHS).[96] Faced with an enormous task, the Division of Indian Health found itself

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[92] Kurt Deuschle, "Untitled Notes," Folder 2, Box 5. Records of the Department of Community Medicine, Mt. Sinai School of Medicine, Mt. Sinai Archives, New York; Kurt Deuschle, "Curriculum Vitae and Publications," Folder 627, Box 85, Subseries 3, Commonwealth Fund Records, The Rockefeller Archive Center.

[93] David S. Jones, *Rationalizing Epidemics: Meanings and Uses of American Indian Mortality since 1600* (Cambridge: Harvard University Press, 2009), 198.

[94] In 1955, McDermott reported that tuberculosis deaths had plummeted. While over one hundred people living in the Fort Defiance area had died from tuberculosis every year in the late 1940s and early 1950s, only six in the area had died from tuberculosis in 1954. "Excerpt Taken from Minutes of Navajo Tribal Council Meeting," January 13, 1955, pg. 1. Folder 7, Box 11. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell. For more on the relationship between the Navajo and the Cornell team, see Jane K. Zaidi, "Transcript of interview with Walsh McDermott."

[95] In 1955 McDermott and his colleague Dr. Carl Muschenheim received the Albert Lasker Award for Medical Research. David S. Jones, "The Health Care Experiments at Many Farms," 766.

[96] Even after this transfer of responsibilities, however, there was still confusion over the differentiation of responsibilities between the PHS and the Bureau of Indian Affairs. For example, although it was agreed that the PHS would take responsibility for those issues that were clearly medical, they often found themselves confronting the Bureau over issues such as water supply, roads, and telephone facilities, which, although technically in the domain of the Bureau, were closely tied to health issues on the reservations. See Walsh McDermott, Kurt Deuschle, Edwin Kilbourne, and David Rogers, "Interim Report on Indian Health to the Commission on the

in need of information. While experts in the Division shared a general consensus that Native Americans were plagued by ill health, they had very little information on what sorts of health issues were the most significant. Realizing that they would first need to conduct extensive research if they were to carry out their new mandate, the PHS called upon Cornell's department of preventative medicine for assistance. Cornell's previous experience with the tuberculosis project made it an obvious partner for the PHS. The PHS asked McDermott and Deuschle to conduct field research, hoping that the project could "serve as a continuous source of documented information" that would better enable them intervene in Native American health.[97]

Thus, what had begun as straightforward research on tuberculosis and isoniazid now evolved into something much more expansive. Instead of working to treat a specific disease, McDermott, teaming up with Kurt Deuschle, sought to create a new program that would "[take] over the responsibility for total health care of a community."[98] As they did so, they were forced to rethink the relationship between themselves as medical professionals and the patient population they were treating. In the process, they increasingly relied on "community" to describe and define the model of health care that they were developing.

From the outset, McDermott and Deuschle sought to couple research with service. Years later, McDermott stated that "it would not have been ethically appropriate to go in and study the Navahos, so to speak, and then do nothing in return." Instead, he believed the "social contract" dictated that the researchers work to deliver improved health care to the population they were

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Rights, Liberties, and Responsibilities of the American Indian," June 30, 1959, Folder 2, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[97] Walsh McDermott, Kurt Deuschle, Edwin Kilbourne, and David Rogers, "Interim Report on Indian Health to the Commission on the Rights, Liberties, and Responsibilities of the American Indian," June 30, 1959, Folder 2, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[98] Jane K. Zaidi, "Transcript of interview with Walsh McDermott."

studying.[99] To achieve both of these goals, McDermott and Deuschle decided to establish a health center, where all services and research activities could be united under one roof.[100] Since they did not have the resources to take on health care for the entire reservation, they chose a sample population of 2,000 people, who were living in an 800-square-mile area known as "Many Farms-Rough Rock."[101] Although they acknowledged that the region was sparsely populated, with residents living sometimes miles away from their closest neighbors, they argued, "The term ["community"] seems justified […] by the fact that the residents of Many Farms and Rough Rock avowedly regard these two adjacent area as 'communities' to which they respectively belong, and the two areas together form an electoral district with a single seat on the 74-member Navajo Tribal Council."[102] The area thus seemed to lend itself well to the proposed health facility, since Cornell could conduct research on what seemed to be a representative sample, while the use of the term "community" allowed them to neatly delineate who would be eligible to receive their services.

From the outset, "community" was closely linked to poverty. The Cornell team was struck by the parallels they saw between the Navajo reservation and the "third world." Robert W. Young, a linguistics professor at the University of New Mexico who was involved in the project, argued that the Navajo reservation was "underdeveloped," suffered from a "depressed economy," and was "characterized by the full range of diseases generally associated with poverty

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[99] Jane K. Zaidi, "Transcript of interview with Walsh McDermott."

[100] In 1970, McDermott referred to this facility as a "neighborhood health center." However, it is unlikely he would have used this language in the 1950s, since the term did not gain traction until the mid-1960s.

[101] Walsh McDermott, Kurt Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, "Introducing Modern Medicine in a Navajo Community, Reprinted from Science," January 22-29, 1960, Vol. 131, Nos. 3395 & 3396, pg. 6. Folder 3, Box 10. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[102] Walsh McDermott, Kurt Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, "Introducing Modern Medicine in a Navajo Community, Reprinted from Science," 6.

and low sanitation."[103] McDermott echoed this sentiment in his reports on the Many Farms project. The "situation of the Navajo," he stated, "is a crude replica in miniature of conditions in many parts of Asia, Africa, and South America."[104]

A dichotomy of "modern" versus "traditional" framed the entire program. In 1960, Rostow's theory of the stages of growth had laid out a specific series of stages of societal evolution. According to Rostow, a society's journey from "traditional" to "mass consumption" could be divided into a series of five distinct stages, all of which were characterized by various levels of economic activity.[105] The quick rise of modernization theory resonated with those working in the Many Farms program, who saw themselves as attempting to bring modern medicine to a "primitive" society. For example, a few years after the program ended, McDermott, sought to apply modernization theory to the work he had done at the Many Farms project. He argued that disease patterns, just like economic growth, could be divided into a series of five stages from primitive to modern. The Navajo, he surmised, were somewhere in the middle of this scale. "The Many Farms pattern," he wrote, "appears to represent a clearly identifiable stage, or plateau, in patterns of community health along the ascending scale from the primitive to the modern."[106] The role of the Cornell doctors was to use their medical expertise to intervene and give the community the needed boost in development. The Many Farms

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[103] Robert W. Young, "Foreword," in John Adair, Kurt W. Deuschle, and Clifford R. Barnett, *The People's Health: Anthropology and Medicine in a Navajo Community*, 2nd ed. (Albuquerque: University of New Mexico Press, 1988), xi-xii.

[104] Walsh McDermott, Kurt Deuschle, Edwin Kilbourne, and David Rogers, "Interim Report on Indian Health to the Commission on the Rights, Liberties, and Responsibilities of the American Indian," June 30, 1959, page 58. Folder 2, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[105] Walt Whitman Rostow, "The Stages of Economic Growth: A Non-Communist Manifesto (Cambridge: Cambridge University Press, 1960).

[106] Walsh McDermott, Kurt W. Deuschle, Clifford R. Barnett, "Technologic Misfit Between a Modern Health Care System and the Demographic/Disease Pattern of Rural Poverty."

experiment, then, was significant because it had been an experiment in “transfer[ring] a fully modernized system of medicine en bloc to a backward overly-traditional rural society.”[107]

McDermott and his colleagues believed they had to do much more than simply make services available to this underserved population. They argued that the unique needs of the Navajo people—much like the needs of those in the third world—called for an innovative sort of program, since “it was not a simple matter to introduce modern medical care to the Navajo where geographic, socioeconomic, language, and cultural barriers existed.”[108] In order to provide effective care, the gulf separating the modern from the traditional would have to be bridged. It was in reaction to these perceived cultural differences, then, that they devised an innovative form of health care delivery.

The Cornell physicians argued that introducing modern medicine to the Navajo community would require a fully integrated, comprehensive approach. The health center they devised reflected these goals. Composed primarily of a central clinical facility, it also included an extensive outreach component consisting of several cars equipped with radio telephones for visiting patients in their homes.[109] The center also employed an eclectic mix of health workers. While its “core” staff consisted of field physicians and public health nurses, the center also pioneered the implementation of a new category of health care worker—the health “visitor.” The health visitor was an “all-purpose subprofessional worker,” “an auxiliary to the field nurse, a

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[107] Walsh McDermott, “Medicine and Modernization--The Navajo Experiment at Manyfarms,” 1965. Folder 8, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[108] John Adair, Kurt W. Deuschle, and Clifford R. Barnett, *The People's Health: Anthropology and Medicine in a Navajo Community*, 22.

[109] Walsh McDermott, Kurt W. Deuschle, Clifford R. Barnett, “Technologic Misfit Between a Modern Health Care System and the Demographic/Disease Pattern of Rural Poverty.”

driver-interpreter, a sanitarian, and a community worker all in one."[110] When the public health nurses were unable to visit all of their patients on a regular schedule, health visitors could often take up the slack, providing the kind of continuous care necessary for infant care or the care of patients with tuberculosis. Furthermore, these health visitors, all of whom were Navajo, acted as bridges between the Cornell physicians and the community, thus playing a vital role in the operations of the Many Farms clinic. In choosing which Navajo to employ as health visitors, McDermott prioritized their "continuity of experience on the Reservation," preferring those who had a history of community involvement to those with more traditional professional qualifications.[111] These health visitors were then tasked with developing working relationships with local community leaders, including medicine men, and they could serve as representatives of the clinic at community meetings.[112] Thus, the development of the health visitor not only allowed the small clinic to provide comprehensive health care to a large and dispersed population, but it also helped to bridge the divide between professional and patient.

Anthropologists also played a key role at the health center. McDermott and Deuschle believed that an in-house anthropologist could aid them in overcoming the "cultural barrier" and reaching the Navajo community. In July 1955, they hired John Adair, a social anthropologist who had spent years working on the Navajo Reservation. Adair quickly became one of the most prominent members of the team, and he and his fellow resident anthropologists, along with

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[110] Walsh McDermott, Kurt Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, "Introducing Modern Medicine in a Navajo Community, Reprinted from Science,"131, no. 3395 & 3396, (1960): 14, Folder 3, Box 10. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

[111] John Adair, Kurt W. Deuschle, and Clifford R. Barnett, *The People's Health: Anthropology and Medicine in a Navajo Community*, 89.

[112] Walsh McDermott, Kurt Deuschle, Edwin Kilbourne, and David Rogers, "Interim Report on Indian Health to the Commission on the Rights, Liberties, and Responsibilities of the American Indian," June 30, 1959, page 114, Folder 2, Box 10, Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.

Cornell consultants in various social sciences who visited regularly, provided the physicians with "continued guidance" about how to best reach the Navajo people.[113] For example, the anthropologists at Many Farms spent years perfecting a system of medical records compatible with the Navajo family structure. The lack of efficient and effective medical records had been an issue that plagued the program in its early days. Navajo naming practices, which relied on kinship terms and nicknames, made it difficult to identify individuals in medical records. Furthermore, because disease often spread among members of the same family units, medical records had to adequately represent and map different kinship groups. Eventually, the anthropologists, working with the nurses, arrived at a solution—a "campfile" system that divided residents into social units, or "camps."[114] In this way, anthropologists adapted "modern" medicine for a "traditional" society.

The apparent distance of the Navajo reservation from the American mainstream, along with its seeming similarities to the underdeveloped third world, also encouraged the Cornell physicians and anthropologists to push the boundaries of what was generally considered the purview of medicine. Uniting medicine and social science, these physicians sought to understand disease in conjunction with culture and community.

When it ended in 1962, the Many Farms program left a number of legacies that shaped American medical schools. The program had not begun as a project in community medicine, but it pioneered a number of what was later known by that term—most significantly, the comprehensive health center that addressed the "total health" of the community. The novel use of social science in a health care setting and the development of the health visitor positions

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[113] Walsh McDermott, Kurt W. Deuschle, and Clifford R. Barnett, "Technologic Misfit Between a Modern Health Care System and the Demographic/Disease Pattern of Rural Poverty."
[114] John Adair, Kurt W. Deuschle, and Clifford R. Barnett, *The People's Health: Anthropology and Medicine in a Navajo Community*, 109-122.

would soon become key features of community medicine projects. Perhaps one of the most influential of these legacies, however, was Dr. Kurt Deuschle, who, after working as director of the Cornell-Navajo project, founded the nation's first community medicine department at the University of Kentucky. Deuschle turned the lessons he had learned from the Cornell-Navajo experience into a distinct new field of medicine that quickly spread among medical schools.

The Kentucky Model

In 1960, William R. Willard, the dean of the University of Kentucky's new medical school, hired Deuschle, charging him with designing a new program of "public health—preventative medicine."[115] Willard, who had a background in public health himself, hoped that Deuschle's interest and experience in "community health research in areas of low economic resources" would make him a good fit for the medical school's focus on rural outreach.[116] Kentucky presented the medical school with a complex set of health problems. Although a few industrial centers were rapidly growing, much of the state—particularly East and Central Kentucky—was mired in rural poverty. Qualified physicians were often unwilling to settle and work in the poorest regions, so many residents lacked access to health care.[117] Furthermore, the University of Kentucky was a land grant university, and many of the faculty of the new medical school believed that this status gave them a unique responsibility to serve the needs of the

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[115] Kurt W. Deuschle and Hugh S. Fulmer, "Community Medicine: A 'New' Department at the University of Kentucky College of Medicine," *Academic Medicine* 37, no. 5 (1962): 434.

[116] "Department of Community Medicine, University of Kentucky, Discussion with Dr. Kurt W. Deuschle, Chairman, Comments by Dr. Heffron." October 19, 1961, page 20. Folder 1661, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

[117] Hugh S. Fulmer, "Teaching Community Medicine in Kentucky," *Harvard Public Health Alumni Bulletin*, 21, no. 2 (1964): 3. Folder 1662, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

population of their state.[118] Land grant universities had historically fostered strong relationships with their communities. In particular, agricultural colleges at land grant universities had been instrumental in relaying new agricultural developments to rural farmers. Willard and Deuschle hoped that a medical school could play a similar part, bringing medical advancements to the rest of the state.

At Kentucky, Deuschle was given an enormous amount of latitude to craft the new department. Encouraged by Willard to be creative, he hired his colleague, Dr. Hugh Fulmer, who had served as field director with Deuschle in the Navajo-Cornell project. Together, Deuschle and Fulmer developed an innovative program, which they labeled "community medicine." Fulmer later said that their idea for a community medicine department had been born during their time at the Many Farms project. Working with Cornell medical students, Deuschle and Fulmer had found these students receptive to a program that combined medicine with some of the traditional aspects of public health. "The *idea* that later led to the development of our program at Kentucky," Fulmer stated, "was generated by the attitude of these students who said in effect, that 'if this is public health, we like it.'"[119]

Deuschle and Fulmer later wrote that they had considered names such as "social medicine" and "preventative medicine," ultimately rejecting them in favor of "community medicine […] because it most closely described the teaching, research, and service responsibilities visualized for the department, and because it was to be aligned with the

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[118] Kurt W. Deuschle, "Community Medicine, Medical Schools, and Land Grant Universities," September 30, 1967, Box 13, Department of Community Medicine Records, Mount Sinai Archives.

[119] Hugh Fulmer, "The Community Medicine Program in Kentucky," *Canadian Medical Association Journal*, 97 (1967), 725. Folder 1676, Box 179. Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

mainstream of medicine."[120] Deuschle and Fulmer both believed that they were pioneering a new field, and they defined the mission of this field broadly. The Department's goal, they stated, was to "[assist] the student in integrating, synthesizing, and applying his medical knowledge to the changing health problems of society."[121] Similarly, they took an expansive view of "community," employing it to denote "a social or population unit, larger than a family, whose members share one or more definable characteristics such as geography, political party, economic level, culture, occupation, and religion."[122] The extraordinary flexibility of this definition privileged capaciousness over intellectual rigor and specificity. Fulmer admitted the definition was more a functional than theoretical one. It was, in summary, he said, "the concept of the application of medicine, broadly defined, to the health problems of the community."[123] The community medicine department, then, would act as the "extramural" arm of the university's medical school, identifying the health problems in the surrounding communities and providing health services to meet those needs.

The community medicine department at Kentucky was an attempt to turn the ideas that had seemed so successful in practice on the Navajo reservation into a separate field of medicine—something that could be applicable in communities across the country. Deuschle blended aspects of community-based model developed on the Navajo Reservation with elements of comprehensive care, combining the former's service to the local population with the latter's

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[120] Kurt W. Deuschle and Hugh S. Fulmer, "Community Medicine: A 'New' Department at the University of Kentucky College of Medicine," *Academic Medicine* 37, no. 5 (1962): 435.

[121] Kurt W. Deuschle and Hugh S. Fulmer, "Community Medicine: A 'New' Department at the University of Kentucky College of Medicine," 435.

[122] Kurt W. Deuschle and Hugh S. Fulmer, "Community Medicine: A 'New' Department at the University of Kentucky College of Medicine," 435.

[123] Hugh S. Fulmer, "Teaching Community Medicine in Kentucky," *Harvard Public Health Alumni Bulletin*, 21, no. 2 (1964): 3. Folder 1662, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

focus on medical education. If the medical school was to address these health problems, it would not only have to provide service, but it would also have to train doctors who would later stay to work in Kentucky. Deuschle and Fulmer envisioned a department that would teach students how to understand disease in the context of the local community, as well as instill in them a sense of responsibility for the rural poor. Teaching was thus a top priority of the department, inextricably intertwined with the twin goals of research and service. The curriculum that Deuschle and Fulmer created mirrored their broad understanding of community medicine, combining epidemiology, vital statistics, preventative medicine, health organization and administration, and even health care financing.[124] The department stressed an interdisciplinary approach and hired a sociologist and an anthropologist for its "Human Ecology" section.[125] All of these subjects, they contended, would be necessary in training future doctors who would understand health and disease within their social contexts.

While the nucleus of the department consisted of a few full-time faculty housed in the medical school, it was the department's work "in the field" that made it unique. As Fulmer put it in a 1961 article about the program, "All of Kentucky has, in a sense, become our 'ward.'"[126] The department set up satellite centers throughout the state, located strategically in areas where

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[124] "A Statement of the Teaching, Research, and Service Aims of the Department of Community Medicine, University of Kentucky College of Medicine," Folder 1659, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.

[125] Anthony C. I. Adams, "Teaching International Community Medicine," 1964, page 102. Folder 1676, Box 179. Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

[126] Hugh S. Fulmer, "Teaching Community Medicine in Kentucky," *Harvard Public Health Alumni Bulletin*, 21, no. 2 (1964): 3. Folder 1662, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

the Department could provide comprehensive health services to the surrounding communities.[127] Furthermore, with the help of physicians, clinics, and county health departments, Deuschle established sixteen "community wards" throughout the state, where seniors could complete their clerkships in community medicine.[128] This senior clerkship was a fundamental component of the community medicine curriculum. Under the guidance of a physician, each student was charged with studying and observing a single community and analyzing its disease pattern. At the end of the assignment, students presented solutions and suggestions that the Medical Center could implement to better address the health needs of the population.[129] By 1963, the community medicine clerkship had become a regular feature of medical education at the University of Kentucky.[130]

For medical schools searching for a model to emulate, Deuschle and Fulmer's experiment at Kentucky soon garnered national attention. Over the course of the next decade, community medicine programs emerged at medical schools across the country. By the early 1970s, Deuschle was able to count 42 medical schools that had established programs in community medicine and another 27 that had dedicated full departments or divisions to the field.[131] Community medicine was never representative of "mainstream" medical education; rather, the

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[127] "A Statement of the Teaching, Research, and Service Aims of the Department of Community Medicine, University of Kentucky College of Medicine," page 4. Folder 1659, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.

[128] "Progress Report to the Commonwealth Fund on the Community Medicine Clerkship Project," January 1, 1964, page 3, Folder 1663, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.

[129] "An Experimental Program in the Teaching of Community Medicine," Folder 1659, Box 179, Commonwealth Fund Records, Grants, SG 1, Series 18, Rockefeller Archive Center.

[130] "Department of Community Medicine, University of Kentucky, Discussion with Dr. Kurt W. Deuschle, Chairman, Comments by Dr. Heffron," October 19, 1961, page 3. Folder 1661, Box 178, Commonwealth Fund Records, Grants, SG 1, Series 18. The Rockefeller Archive Center.

[131] Kurt Deuschle, "Letter to William Rawls," April 4, 1973, Box 13, Department of Community Medicine Records, Mount Sinai Archives.

postwar system of specialization and fragmentation remained dominant. But by the 1960s the ideas espoused by proponents like McDermott and Deuschle had secured a firm footing within medical schools, garnering a small but dedicated following.

In 1968, Deuschle accepted a position as Chairman of Department of Community Medicine at the Mount Sinai School of Medicine in New York City, where he sought to apply community medicine to the "city block."[132] At Mt. Sinai, Deuschle fused education, research, and service, applying the approaches he had pioneered in rural Kentucky to the East Harlem community in New York City. At his investiture as chairman, for instance, Deuschle called for a partnership between the department and the East Harlem Health Center operated by the city. Such a working relationship, Deuschle argued, would "assure the translation of the latest scientific advances to the practice of medicine and health care in the community."[133]

In a fitting gesture, Dr. Walsh McDermott, Deuschle's former colleague from the Navajo-Cornell project, also spoke at Deuschle's investiture, touting the advantages of community medicine. Both men had been instrumental in pioneering community medicine over the past decade, transforming what was an abstract concept into a new field of medicine. While their Many Farms project had firmly established the concept of the community health center, with its concomitant focus on the "total health" of the community, their later work in medical schools had legitimized community medicine as a full-fledged academic field. That they had both achieved chairmanships by the late 1960s seemed to symbolize community medicine's newfound place in the medical school curriculum.

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[132] Kurt Deuschle, "Letter to Charles Goodrich," April 10, 1968, Box 13, Department of Community Medicine Records, Mount Sinai Archives.

[133] Kurt Deuschle, *Transcript of Investiture Speech*, February 14, 1969. Box 13, Department of Community Medicine Records, Mount Sinai Archives.

CHAPTER 2

“An Instrument of Social Change”: Community Health and the Civil Rights Movement

In 1956, the *New York Times* published an article by Jack Geiger, a medical student at Western Reserve Medical School. In the article, titled “The Patient as a Human Being,” Geiger praised recent developments in medical education, arguing that the turn toward patient-centered approaches had served as an important corrective “in an era of specialized medicine.”[134] Charting the recent changes in medical school curriculums, including those at his home institution, an optimistic Geiger predicted that these programs would produce doctors who “have learned from the start to lift their eyes from the symptom to the whole man, from the infant’s weight-gain chart to the whole family, from the family to its social and economic environment in search the forces that shape its life.”[135]

Geiger’s article made no specific mention of “community,” but, just a decade later, he would be considered one of the pioneers of the community health movement. Historians searching for the origins of the community health movement of the 1960s generally focus on Geiger, arguing that he “imported” the community health model from South Africa.[136] This

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[134] H. Jack Geiger, “The Patient as a Human Being,” *New York Times*, December 2, 1956, pg. 294.

[135] H. Jack Geiger, “The Patient as a Human Being,” *New York Times*, December 2, 1956, pg. 298.

[136] Many historians, for example, state that Geiger brought the Karks’ model to the United States, but they generally do no explore what this process entailed. In her book *More than Medicine,* for example, Jennifer Nelson writes that Geiger “imported the seeds for the community medical center that was built in Mound Bayou, Mississippi, from Pholela, South Africa.” However, she does not examine how this importation might have worked, or why Geiger might turn to an international model as a solution for Mississippi. Jennifer Nelson, *More than Medicine: A*

chapter, however, takes a very different approach. While Geiger remains a key figure in this narrative, this chapter argues that the roots of community medicine in the U.S. were more indigenous than previous accounts have suggested. The community health center model, it posits, arose from the confluence of socially-minded physicians like Geiger and the on-the-ground efforts of civil rights activists.

By the start of the sixties, community medicine had begun to make inroads in medical education, thanks to the efforts of a handful of innovative doctors like Walsh McDermott and Kurt Deuschle. Promising to unite medical teaching, research, and service, community medicine appealed to innovative doctors who sought to expand medicine's reach beyond hospital walls. Community medicine quickly became a buzzword in medical education, but, outside a few select schools, it seemed destined to remain little more than a footnote in medical practice—an extracurricular activity for medical schools that would not threaten the status quo. Over the next few years, however, major political shifts invigorated and radicalized the practice of community medicine, reshaping the very meaning of "community." In 1982 Dr. Fitzhugh Mullan, looking back on the past few decades of American medicine and medical academia, wrote, "Sometime in the early 1960s the notion of community medicine erupted."[137]

The social upheavals of the sixties—especially the civil rights movement—set the stage for the sudden rise of community medicine. Radical politics, stultified in the fifties, resurfaced in the sixties, galvanizing a new generation of health care activists. Although they remained a minority, this increasingly vocal strain of medical activists sought to apply their professional expertise to social problems. Health care, they proclaimed, could be "an instrument of social

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History of the Feminist Women's Health Movement (New York: New York University Press, 2015), 23.

[137] Fitzhugh Mullan, "Community Medicine Revisited (Draft)," April 30, 1982. Folder 6, Box 5, Department of Community Medicine Records, Mount Sinai Archives.

change."[138] Years later, Geiger wrote, "What happened at the start was a rare convergence of forces and events. The key players were activist medical students and physicians." As he remembered it, "Great social upheavals […] provided the pathways to health care innovation."[139]

In tracing the development of community medicine, this chapter makes use of recent developments in the historiography of social movements. Since the 1980s, scholars of social movements have been moving to a more complex understanding of the process of diffusion of social movements. Until the 1990s, the "contagion" model still dominated much of the thinking about social movements. According to this model, ideas and knowledge spread from one individual to another until they became a full social movement. More recently, however, new theories have challenged and complicated this model. Whereas the contagion model primarily conceived of individuals as passively receiving and absorbing ideas, the new model understood these individuals to be active participants in the diffusion process. Ideas did not simply move unaltered from person to person; rather, individuals adopting new ideas were constantly translating and "reframing" these concepts for their own purposes and contexts. Compared to the "nonrational and nonagentic" contagion model, then, these new theories allowed for more flexibility. Ideas, then, were not stagnant, but always changing and adapting.[140] Discarding the

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[138] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984).

[139] H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents" in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home*, ed. Anne-Emanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 117-118.

[140] James E. Stobaugh and David A. Snow, "Temporality and Frame Diffusion: The Case of the Creationist/Intelligent Design and Evolutionist Models from 1925 to 2005," in *The Diffusion of Social Movements: Actors, Mechanisms, and Political Effects*, ed. Rebecca Kolins Givan, Kenneth M. Roberts, and Sarah A. Soule (Cambridge: Cambridge University Press, 2010), 35.

contagion model created myriad new possibilities for scholars to think more creatively about the spread of social movements.

The implications of these changes in understanding diffusion are perhaps most prominent in the study of transnational networks. Examining how ideas could be "reframed" for different contexts allowed scholars to study how actors from different cultures imported and translated concepts acquired abroad. The political scientist Conny Roggeband, for example, wrote, "Diffusion is a political process in which actors at different levels adopt and adapt foreign examples to make national and transnational claims and change institutional and legal settings, build alliances, and exert pressure."[141] In U.S. history, this line of inquiry has been especially productive in expanding historians' understanding of the civil rights movement, allowing historians to see, for instance, how civil rights activists imported Gandhian concepts of nonviolence and reframed them for their American context. However, this new work on diffusion has been, for the most part, underutilized. As sociologists James Stobaugh and David Snow point out, most studies of diffusion have been limited to cases of clear-cut transfer over short periods of time.[142]

Community, like nonviolence, was not a static idea: rather, it evolved and took on new meanings during the ferment of the early 1960s. Much of this process took place on the ground in Mississippi—in the midst of the civil rights movement. During the summer of 1964, the Medical Committee for Human Rights (MCHR) sent doctors, medical students, nurses, and other health care workers to Mississippi to provide medical assistance to the civil rights activists trying

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[141] Conny Roggeband, "Transnational Networks and Institutions: How Diffusion Shaped the Politicization of Sexual Harassment in Europe," in *The Diffusion of Social Movements: Actors, Mechanisms, and Political Effects*, Eds. Rebecca Kolins Givan, Kenneth M. Roberts, and Sarah A. Soule (Cambridge: Cambridge University Press, 2010), 22.
[142] Stobaugh and Snow, "Temporality and Frame Diffusion," 35.

to organize Mississippi voters. Despite its limited initial goals, the organization quickly broadened its efforts to provide health care to Mississippi's poor and experimented with new approaches to health care delivery. In the process, these activist medical professionals redefined and reframed community medicine.

The community medicine movement that emerged from this milieu incorporated much of the language and philosophy of community participation and empowerment of the civil rights activists. While the advocates of community medicine of the 1950s had used the term "community" mostly in an epidemiological sense, these medical activists, inspired by the civil rights movement's focus on "community" as the wellspring of "grassroots democracy" and "authentic leadership," imbued the term with a new set of connotations.[143] "Community" was thus both a medical term and a political one—the convergence of radical politics and medicine.[144]

Health Activism in the 1960s

The sixties transformed the political landscape, but a paradox was emerging. Although confidence in medicine's abilities had never been higher, the early 1960s saw the emergence of new concerns over the organization of medical care. While medical schools and teaching hospitals had flourished in the postwar era, this institutional web had left many of the nation's elderly and poor without access to quality health care. Critics worried that the nation's health

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[143] For more on the civil rights movement and participatory democracy, see Terrence E. Cook, *Participatory Democracy* (New York: Harper & Row Publishers, 1971); Francesco Polletta, *Freedom is an Endless Meeting* (Chicago: University of Chicago Press, 2002).

[144] In the preface to *White Coat Clenched Fist*, Mullan says that the "intersection of radical politics and American medicine" was a small but "enduring" one. Fitzhugh Mullan, *White Coat Clenched Fist: The Political Education of an American Physician* (Ann Arbor: University of Michigan Press, 2006), ix-x.

care system was too fragmented, and many pushed for new, redistributive reforms to ameliorate the system's weaknesses.[145]

At the top of this list of reforms was Medicare. Though the American Medical Association (AMA) had long fought reformers' efforts to pass government health insurance, liberals were able to harness public pressure for a program by focusing on the elderly, a group widely understood to be "deserving" of government support.[146] The campaign for Medicare gained ground in the early sixties, with support—as one magazine put it—"assuming the proportions of a crusade."[147] After Lyndon B. Johnson's landslide victory in 1964 and the concomitant Democratic sweep of Congress, the bill moved to the front of the Congressional agenda. In July 1965, President Johnson signed both Medicare and Medicaid into law, demonstrating his administration's commitment to health care reform and adding a new dimension to the federal government's involvement in health care.[148]

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[145] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 367.

[146] The notion of the deserving versus the underserving poor has a long history in American social welfare policy. Michael B. Katz, *The Undeserving Poor: America's Enduring Confrontation with Poverty*, 2nd ed. (New York: Oxford University Press, 2013).

[147] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 368.

For more on the campaign for Medicare and its place in a larger struggle for health care reform, see Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No National Health Insurance* (New York: Oxford University Press, 2005); Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2013); Theda Skocpol, *Health Care Reform and American Politics: What Everyone Needs to Know* (Oxford: Oxford University Press, 2012); Rosemary Stevens, *American Medicine and the Public Interest* (Berkeley: University of California Press, 1998).

[148] Paul Starr argues that, although Medicare and Medicaid were twin pieces of legislation, they diverged sharply. Whereas Medicare was a federal program that dealt with a population largely seen as "deserving," Medicaid was largely left to the states, making it far more limited in practice. Paul Starr, *The Social Transformation of American Medicine*, 370.

In many ways, this divergence reflects what many historians have called a "two-tiered" welfare state, in which some welfare policies are considered "rights" (and usually administered at the federal level) and others are viewed as "handouts" (and left to the states to distribute). For more

While liberal reformers pushed for expanding coverage through government programs like Medicare and Medicaid, a new strain of medical activists hoped for a more fundamental reorganization of health care. The idea of inequality in health care was not new, but the political climate of the sixties instilled it with a new sense of urgency. In particular, the civil rights movement drew attention to racial disparities in health care.

In June 1963, thirty doctors picketed outside an AMA meeting in Atlantic City, demanding the AMA sever ties with any affiliates that refused to admit African-American members. The picket was the first action of the Medical Committee for Civil Rights (MCCR), an organization that had formed two weeks earlier, when medical activist Walter Lear teamed with John L.S. Holloman, an African-American doctor from New York and a member of the National Medical Association (NMA), the African-American counterpart to the AMA. Together, Lear and Holloman called for an end to discrimination in "all phases of medicine and health services."[149]

The MCCR targeted racial inequality on both sides of the doctor-patient relationship, fighting discrimination against black physicians and other black health care workers, as well as against black patients. On the physician side, for example, the MCCR fought for the inclusion of African-American physicians into the medical societies that constituted the AMA. Though the AMA did not explicitly ban African Americans from its ranks, it allowed its constituent societies

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on the idea of a two-tiered welfare state, see Linda Gordon, *Pitied But Not Entitled: Single Mothers and the Origins of Welfare, 1890-1935* (New York: The Free Press, 1994); Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (New York: Oxford University Press, 1994); Mary Poole, *The Segregated Origins of Social Security: African Americans and the Welfare State* (Chapel Hill: University of North Carolina Press, 2006).

[149] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*. New York: Bloomsbury Press, 2009), 16.

to discriminate as they saw fit.[150] On the patient side, the MCCR targeted the refusal of hospitals across the country to admit African Americans.[151] The Hill-Burton Hospital Construction Act, which had funded many of the hospitals built after World War II, allowed for "separate-but-equal" hospital facilities.[152] The AMA tacitly supported such discrimination, claiming that it was a matter of local, not national, concern.

Walter Lear, like many of the early members of the MCCR, had a long history of activism. Prior to founding the MCCR, he had been on the executive board of the Physicians Forum, where he had championed universal health care rights. Most of the members of the New York-based Physicians Forum were white doctors with socialist sympathies, and many of them, for example, had been politically active in the Communist Party of the 1930s. By the early 1960s, the emerging civil rights movement had inspired Lear to confront issues of racial discrimination in health care.

As Lear and other left-leaning activists were beginning to look more closely at racial discrimination, the NMA was also undergoing a shift.[153] Formed in 1895, the NMA gave a unified professional voice to black physicians who were excluded from many of the medical

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[150] Susan L. Smith, "National Medical Association," in *Organizing Black America: An Encyclopedia of African American Associations*, ed. Nina Mjagkij (New York: Garland Publishing, 2001): 407-408.

[151] Jennifer Nelson, *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015): 19-20.

[152] According to political scientist David Barton Smith, this provision was "the only one in federal legislation of this century that explicitly permitted the use of federal funds to provide racially exclusionary services." David Barton Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor: University of Michigan Press, 1999), 47.

[153] For literature on African Americans and the fight against racial inequality in health care, see Edward H. Beardsley, *A History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth-Century South* (Knoxville: University of Tennessee Press, 1987); David McBride, *From TB to AIDS: Epidemics Among Urban Blacks Since 1900* (Albany: State University of New York Press, 1991); Susan L. Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950* (Philadelphia: University of Pennsylvania Press, 1995).

societies that made up the AMA. Inspired by Booker T. Washington's philosophy of self-help, the organization had launched a black hospital movement in the early twentieth century in order to give African-American physicians a place to practice medicine.[154] In the late 1930s, the NMA lobbied the AMA for inclusion into its ranks, arguing that NMA membership should guarantee physicians entrance into the AMA. This effort was short-lived. The AMA rejected its proposal and the NMA backed off, remaining largely silent on the issue for decades.[155]

The movement for hospital integration resurfaced in the 1950s, when the civil rights movement pushed the NMA to take a more aggressive stance on civil rights. After the 1954 Supreme Court ruling in *Brown v. Board of Education* began to dismantle the legal apparatus of "separate but equal," separate hospitals seemed less palatable. Instead, an increasing number of black leaders pushed for hospitals to abolish racial discrimination and to allow both black physicians and black patients to use their facilities.[156] In 1957, the leader of the NMA, Dr. W. Montague Cobb, established the Imhotep Conference, named for an ancient Egyptian doctor, to promote equal treatment of African Americans in medicine.[157]

One regular attendee of the Imhotep conferences was Walter Lear, who became increasingly convinced that it was necessary to tackle the AMA's discriminatory racial practices. He and Holloman planned a picket line at the upcoming AMA conference in Atlantic City and, in the process, created the Medical Committee for Civil Rights. The ensuing Atlantic City protests, and the founding of the MCCR more generally, thus marked the coming together of white leftist

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[154] For more on the black hospital movement, see Vanessa Worthington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995).
[155] John Dittmer, *The Good Doctors*, 12-13.
[156] Susan L. Smith, "National Medical Association," 408.
[157] John Dittmer, *The Good Doctors*, 12.

doctors and black NMA physicians.[158] Though the MCCR was predominantly white, its commitment to interracial reform distinguished it from its predecessors and marked a new stage in the history of medical activism. Organizations such as the Physicians Forum had long championed universal health care rights, but the MCCR was the first to explicitly tie those efforts to the African-American struggle for civil rights.

In mixing activism and medicine, the MCCR was treading carefully. In Atlantic City, the picketers—a mix of both black and white physicians—marched in suits and displayed their signs on sandwich boards on the Boardwalk. Asked by the police chief why they did not carry the signs instead, Walter Lear, one of the founders of the group, replied simply, "Doctors do not carry picket signs."[159] Lear's statement hinted at some of the tensions inherent in the doctors' role. Although they considered themselves both professionals and activists, the doctors expressed some discomfort with typical activist methods and sought to project their professionalism. They believed their status as physicians made them uniquely qualified to speak out against discrimination in medical services. At the same time, however, years of red-baiting had taken their toll on the medical left, drawing a firm line between doctors' professional activities and their political interventions.[160] Many worried that losing themselves too completely in the role of activist would undermine their professional standing. This tension in the role of doctor-activist remained a recurring issue for the MCCR as the organization navigated the turbulent politics of the sixties.

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[158] Though some of the members of the NMA participated in the Atlantic City protests, the organization refrained from any official involvement.
[159] John Dittmer, *The Good Doctors*, 16.
[160] Jenna M. Loyd, *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014): 39.

After the Atlantic City protests, MCCR membership grew rapidly but then declined.[161] A lull in racial confrontations in the South caused the civil rights movement to fall out of national headlines. The MCCR lost momentum and funding, and the organization was broke and defunct by the end of the year.[162]

The fight for hospital integration continued in the courts, however. Pursuing the same line of legal justification they had used to dismantle segregation in education in *Brown v. Board of Education*, the NAACP Legal Defense Fund successfully challenged the separate-but-equal provision of the Hill-Burton Act. In 1963, the Fourth Circuit Court of Appeals ruled in *Simkins v. Cone* that the provision violated the Fifth and Fourteenth Amendments, dealing a significant legal blow to state-backed segregation in health care.[163] The MCCR's legacy also left a legislative impact. In July 1963, Lear testified for the MCCR before the House Judiciary Committee. At the hearing, Lear pushed for the public accommodations section of the Kennedy civil rights bill to be expanded to include "non-profit, non-governmental hospitals, nursing homes, clinics, and the health facilities which provide an essential public service that would otherwise be provided by government agencies."[164] When the final bill was passed as the Civil Rights Act of 1964, it incorporated Lear's broader vision, banning discrimination in any health facility that received government funds.

Segregation and discrimination stubbornly persisted. While some southern hospitals refused to integrate, others found more indirect ways to circumvent the new law. Many hospitals, for instance, converted to private rooms—often at considerable cost—to avoid integration.

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[161] John Dittmer, *The Good Doctors*, 21, 19.
[162] John Dittmer, *The Good Doctors*, 24-25.
[163] P. Preston Reynolds, "Professional and Hospital Discrimination and the US Court of Appeals Fourth Circuit 1956-1967," *American Journal of Public Health* 94, no. 5 (2004): 710-720.
[164] John Dittmer, *The Good Doctors*, 19.

Others refused to give hospital privileges to black doctors, thereby effectively blocking the admission of their black patients.[165] In Mississippi, the Mississippi State Sovereignty Commission—an official government entity created in 1956 to fend off efforts at desegregation after *Brown v. Board of Education*—actively investigated and fought attempts to integrate the state's hospitals, inventing serpentine measures that tested the limits of the new law.[166] The commission recommended that hospitals make nominal concessions that would give the superficial appearance of integration without making any fundamental changes. These recommendations could cover even the most detailed minutiae. In a report on the University of Mississippi Medical Center, for example, the commission suggested that the Center get rid of segregated drinking fountains and replace them with individual cups. It also recommended that administrators remove all "white" and "colored" signs from bathroom doors but then close the bathrooms that were located near both the "white" and "colored" areas of the center (and thus most likely to be used by members of both races). The director of the commission hoped that these concessions would "test" the federal government. If successful, the concessions could "forestall the cut-off of federal funds either temporarily or perhaps permanently." On the other hand, if the federal government stepped in to cut off the Center's funding the Center would then need to decide "whether to comply in full or seek to make a concerted effort to find other sources to replace these federal funds."[167] Mississippi's willingness to engage in this game of "chicken" with the federal

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[165] Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (Chicago: The University of Chicago Press, 2012): 126-27.

[166] David Smith Barton's article on desegregation in Jackson, Mississippi, shows the often considerable lengths that some hospitals were willing to go to in order to preserve segregation. David Barton Smith, "The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi," *Milbank Quarterly* 83, no. 2 (2005): 247-269.

[167] David Smith Barton, "The Politics of Racial Disparities," 260.

government highlights the state's commitment to segregated hospitals, as well as the uphill battle that medical activists faced in their efforts to eradicate racial inequality in health care.

Southern intransigence caused civil rights strategists to divide over what their next steps should be. The Student Nonviolent Coordinating Committee (SNCC) advocated continuing its program of grassroots community organization—the gradual, long-term, but decidedly unflashy strategy that they had pursued in Mississippi since the summer of 1961. On the other hand, many leaders of the Council of Federated Organizations (COFO), the umbrella organization formed in 1962 to coordinate SNCC and other movement groups, believed that the movement needed to attract national attention and shock an otherwise apathetic public into supporting federal intervention. In the fall of 1963, the two groups envisioned a program that would unite this grassroots activism with the need for national publicity.[168] Called "Freedom Summer," the program they proposed would bring thousands of volunteers down to Mississippi to register voters and set up the new Freedom Democratic Party. But there was another, more cynical, element to this strategy: the American public might be unmoved by the murders of black activists in Mississippi, but the arrival of a group of mostly white college students would change this calculus. COFO leaders hoped that the attention and visibility of the program would pressure the federal government to act.[169]

Freedom Summer

Mississippi in the early sixties was ground zero for a new form of community organizing in the civil rights movement. Whereas the Southern Christian Leadership Conference (SCLC)

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[168] Though SNCC and COFO hoped to unite these goals in Freedom Summer, many SNCC activists became increasingly skeptical that the tensions between these two impulses could be reconciled. See Clayborne Carson, *In Struggle: SNCC and the Black Awakening of the 1960s* (Cambridge: Harvard University Press, 1981), 111.

[169] John Dittmer, *The Good Doctors*, 30-31.

relied upon a "hit-and-run" strategy that moved from one community to the next, SNCC focused on long-term organizing.[170] Founded in 1960 by student activists participating in the sit-in protests in the South, the organization quickly developed a more hands-on strategy, working directly with local communities across the South to organize civil rights campaigns.[171]

SNCC activists took issue with the strict hierarchy of many of the civil rights organizations. In contrast to the authoritarian style of leadership that privileged the decision-making of a few—usually middle-class and male—charismatic leaders, SNCC activists pioneered a new, more egalitarian philosophy of leadership.[172] Guided by the civil rights activist Ella Baker, these activists conceived of an organizing style that relied on identifying indigenous leaders and fostering local autonomy. Baker's commitment to participatory democracy pervaded the organization, shaping both its internal operations and providing a model for its civil rights work.[173]

Baker believed deeply in the power of radical democracy. The job of organizers, she argued, was not to lead a movement, but rather to mobilize the community to identify and make its own demands. Social change should originate with the oppressed, not with those who presumed to speak for them: "I believe firmly in the right of the people who were under the heel to be the ones to decide what action they were going to take to get [out] from under their oppression."[174] At the same time, SNCC's commitment to grassroots change was practical as

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[170] Adam Fairclough, *To Redeem the Soul of America: The Southern Christian Leadership Conference and Martin Luther King, Jr*. (Athens: University of Georgia Press, 2001, 7.

[171] Julian Bond, "SNCC: What We Did." *Monthly Review* 52, no. 5 (2000), 16.

[172] Charles M. Payne, *I've Got the Light of Freedom: The Organizing Tradition and the Mississippi Freedom Struggle* (Berkeley: University of California Press, 2007), 67.

[173] For a more thorough account of Baker's philosophy and its impact on SNCC, see Barbara Ransby, *Ella Baker and the Black Freedom Movement: A Radical Democratic Vision*. (Chapel Hill: University of North Carolina Press, 2003).

[174] Barbara Ransby, *Ella Baker and the Black Freedom Movement*, 195.

well as philosophical. The federal government, the organization's leaders reasoned, was more likely to heed demands that came directly from the community. "The only time feds or anyone else…preserve and protect the people's interest," they noted, "is when the people have the capacity to make a demand."[175]

In order to put these ideals into practice, SNCC instructed its workers to take their cues from the community. When entering a target community, SNCC would send a few field workers to conduct research on the local political and economic history. The field workers would often spend weeks meeting with local leaders and canvassing local residents door-to-door. Julian Bond, a co-founder of SNCC, wrote that when SNCC worked in a community, its goal was to create "a community movement with local leadership, not a new branch of SNCC."[176]

Much of SNCC's work focused on voter registration, and Mississippi was the epicenter of these efforts. To SNCC, voter registration was a key component of organizing a community. As a SNCC report asserted, "More than a mere effort to participate in statecraft; it [was], in a larger sense, the process of extending hope to an almost hopeless segment of the national community."[177] In September 1963, SNCC activists led a "Freedom Vote" campaign, inviting white college student volunteers into the state to help hold mock elections in which African Americans could vote for the state's governor and lieutenant governor. Over 8,000 African Americans cast ballots, and the campaign generated national publicity.[178]

The Freedom Vote of 1963 presented a successful model of a grassroots effort that was able to harness national attention to its advantage. Later, when national attention seemed to be

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[175] Daniel Perlstein, "Teaching Freedom: SNCC and the Creation of the Mississippi Freedom Schools," *History of Education Quarterly* 30, no. 3 (1990): 298-99.

[176] Barbara Ransby, *Ella Baker and the Black Freedom Movement*, 279.

[177] Daniel Perlstein, "Teaching Freedom: SNCC and the Creation of the Mississippi Freedom Schools," *History of Education Quarterly* 30, no. 3 (1990): 300.

[178] Julian Bond, "SNCC: What We Did." *Monthly Review* 52, no. 5 (2000): 21.

flagging in 1964, activists looked again to generate widespread publicity. Despite some qualms about the efficacy of short-term volunteers, SNCC and COFO built on the model of the Freedom Vote and expanded it. Over a thousand volunteers came to Mississippi for Freedom Summer in 1964, propelling Mississippi into the forefront of the national stage. The project shone, Moses later said, "a searchlight from the rest of the country on Mississippi."[179]

With the prospect of thousands of volunteers descending upon the state for a summer, a new problem arose: who would provide for their health care? White Mississippi doctors would likely be reluctant to provide health services to these "outside agitators." Meanwhile, the entire state of Mississippi only had about fifty African-American doctors, and the probable threat of retribution would deter many of them from actively helping the Freedom Summer volunteers. Only a few African-American doctors had identified as allies of the civil rights movement and agreed to openly assist activists' efforts. One of these allies, Dr. Robert Smith, had marched with MCCR activists in Atlantic City, and he recommended that SNCC staff contact one of the activists who had marched with him—the psychologist Tom Levin from New York.[180]

Under the auspices of COFO, Levin began recruiting physicians in New York. Starting with his own social circle of left-wing Jewish physicians, Levin then expanded outward, recruiting health care workers from Jacobi Hospital and Albert Einstein College of Medicine. On July 5, 1964, just as the Freedom Summer project had gotten underway in Mississippi, Levin and his delegation of doctors met with civil rights leaders and black doctors in Jackson, Mississippi, to hammer out the details of the working relationship between the health care workers and the civil rights activists. They agreed that health care workers would "visit and

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[179] John R. Rachal, "We'll Never Turn Back: Adult Education and the Struggle for Citizenship in Mississippi's Freedom Summer," *American Educational Research Journal* 35, no. 2 (1998): 175.
[180] John Dittmer, *The Good Doctors*, 31.

counsel with civil rights workers," as well as provide first aid during marches and demonstrations.[181] Levin's delegation quickly set up a headquarters in New York City and an office in Jackson and called themselves the Medical Committee for Human Rights (MCHR). In adopting a name that echoed the now-defunct Medical Committee for Civil Rights, the MCHR signaled its intention to fill the vacuum left by the decline of the former organization and revive the role of the physician-activist.

As college students poured into Mississippi, they were accompanied by over one hundred MCHR volunteers. The MCHR sent teams of volunteers to COFO projects across the state, often with little direct guidance. Although these volunteers had initially hoped to practice medicine, the Mississippi Department of Health made this impossible. Led by the segregationist Archie Gray, the Department refused to license MCHR doctors in Mississippi, prohibiting them from administering anything more than first aid.[182] Instead, these physicians often found themselves without clear directives, trying to offer help as they saw fit. In addition to providing first aid and other minor medical care, these doctors and nurses led public health programs in the local communities.[183] MCHR volunteers, for example, gave lectures on health care at the "freedom schools" established by COFO activists. Elsewhere, they helped local residents build systems to carry fresh water into their towns.[184]

Freedom Summer galvanized medical activism in the sixties. The MCHR began the summer with a hazy sense of its own goals, but, for many volunteers, their experiences in Mississippi helped to crystallize their own sense of purpose. Though doctors and nurses had

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[181] John Dittmer, *The Good Doctors*, 35.
[182] John Dittmer, *The Good Doctors*, 36.
[183] Charles M. Goodrich, "Medical Committee for Human Rights: Report on Activities," August 10, 1964. Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.
[184] John Dittmer, *The Good Doctors*, 52.

arrived in Mississippi already committed to the cause, they were stunned by the level of need they observed in the state's communities and the harshness and violence of white supremacy. In a report to MCHR officials, one nurse, Judith Hasselberger, described her astonishment at the conditions she encountered: "Despite working recently in a so-called 'underdeveloped' country in Africa, I returned from Mississippi more profoundly disturbed over the avoidable and unnecessary medical problems there."[185] After Freedom Summer, many of medical professionals returned to their hospitals and medical schools across the country, newly emboldened by their foray into activism.

In many ways, the MCHR's participation in Freedom Summer had been more of an emergency response to a crisis than a coordinated, cohesive program. It had attracted a variety of doctors, nurses, and other health care workers who shared a commitment to the cause of the civil rights movement, but it lacked a unifying vision for how health care workers could best contribute to that cause. It was only after the volunteers had come home that MCHR officials had time to regroup and reassess their involvement. On September 12, MCHR members gathered in New York City and adopted a statement of purpose that went beyond the activities of the summer, acknowledging the dire conditions they had seen among Mississippi's rural poor: "We are deeply concerned with the health needs of the socially deprived. It is our purpose to initiate activities to improve their health status and to provide professional support and assistance to organizations concerned with human rights."[186]

As these members planned their future, their relationships with SNCC and COFO were already fraying. SNCC leader Jesse Morris seemed to voice a common sentiment when he wrote

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[185] Judith Hasselberger, "Report," Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[186] John Dittmer, *The Good Doctors*, 62.

a report critiquing the use of short-term volunteers. Morris argued that the MCHR "could have contributed more, if it had concentrated solely on serving the needs of local people…There is an overwhelming need for some type of health program to begin, and relatively soon."[187] Likewise, many within the MCHR were dissatisfied with the organization's approach. After seeing the poverty of many communities in Mississippi, many pushed for an approach that would tackle health inequality more systematically. In evaluating the successes and failures of the summer, MCHR officials recognized the need to shift its strategy away from short-term volunteers to a long-term program.

At the same time, a debate on the role of health care professionals beset the MCHR, centering around a fundamental question: should the MCHR take on the responsibility of providing direct medical care to the (primarily poor and African-American) residents of Mississippi? On one side, Dr. Walsh McDermott, a public health figure and a sponsor and supporter of the MCHR, pushed for a conservative approach, arguing that intervening directly could threaten the professionalism of the doctors. Like the Atlantic City picketers, McDermott believed that there was a thin line between "doctor" and "activist," so doctors fighting for civil rights should tread carefully.[188] In a letter to Dr. Constance Friess, a physician on the board of the MCHR, McDermott wrote, "The deeper the professional gets involved in human rights, the more he tends to lose his professionalism. For, the essence of professionalism is its detachment."[189] Instead of direct intervention, McDermott argued, the MCHR should strive to become an "honest broker" between Mississippi's poor and the existing health authorities in the

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[187] John Dittmer, *The Good Doctors*, 63.

[188] Leslie A. Falk, "The Negro American's Health and the Medical Committee for Human Rights," *Medical Care* (1966): 171-175.

[189] Walsh McDermott, "Letter to Constance Friess," September 1, 1964. Folder 160, Box 14, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

state. MCHR physicians and nurses, for example, could help locate health services in the state that were willing to help African Americans and put those services in touch with the people who desperately needed them. McDermott's suggestion relied on the assumption that such services existed: "If one started with the assumption that there exist today facilities and services in the state of Mississippi that are not actually being utilized to the full because the uneducated Negro does not know their existence, you might find a small crack in the wall that could gradually be enlarged."[190] When faced with balancing activism and professionalism, McDermott advised leaning towards the latter.

McDermott's warnings about the boundaries of professional action, however, were drowned out by the voices of the medical volunteers who had observed firsthand the conditions in Mississippi. McDermott's model of finding a "small crack in the wall" seemed naive in regions where these health services simply did not exist. Despite McDermott's concerns that professionalism and activism were incompatible, the divisions between medical personnel and civil rights organizers blurred on the ground. There, a new, more interventionist strategy was beginning to emerge, driven primarily by the efforts of Jack Geiger, who was then a MCHR field coordinator with a long history of civil rights involvement.

According to the historian John Dittmer, the MCHR delegation to the South included two distinct "factions," each drawn to Mississippi for different reasons. The first—the civil rights faction—was focused on providing aid to the civil rights workers.[191] These activists, of whom Levin was one, were more interested in supporting the civil rights movement and overturning segregation than in reforming the health care system. The other faction—the public health

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[190] Walsh McDermott, "Letter to Constance Friess," September 1, 1964. Folder 160, Box 14, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.
[191] John Dittmer, *The Good Doctors*, 40.

camp—consisted of doctors with backgrounds in public health whose primary goal was a complete overhaul of Mississippi's health system. These activists hoped that their intervention would have long-term, far-reaching consequences for the way in which health care was distributed. Recognizing that inequalities in health care were not confined to the South, many, in fact, saw their work in Mississippi as a way of experimenting with medical reforms that could contribute to a more just health system across the nation. In the wake of Freedom Summer, it was the latter faction, with its focus on health care reform, that played the largest role in devising the MCHR's long-term strategies. In particular, Geiger, one of the most prominent members of this camp, pushed to extend the MCHR's presence in Mississippi, convinced that Freedom Summer was only the beginning of a larger intervention in Mississippi health care.

Having traveled from Boston to Mississippi that August to serve as the MCHR field coordinator, Geiger quickly emerged as a leader in the organization. More than any of the others involved in MCHR, he saw the long-term implications of the work in Mississippi and imagined the organization's efforts as the beginning of a larger effort to unite health care and the civil rights movement and employ "health care as an instrument of social change."[192] The son of German Jewish immigrants in New York, Geiger's commitment to civil rights activism predated his medical career. In 1942, as a journalism student at the University of Wisconsin, he was recruited by civil rights leader Bayard Rustin to campaign against racial discrimination in federal defense plant employment. The following year, Geiger worked with James Farmer, the founder of the Congress of Racial Equality (CORE) to establish a chapter of the organization in Madison, Wisconsin. After three years of service in the Merchant Marine during World War II, Geiger

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[192] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984).

returned to school, this time as a pre-med student at the University of Chicago. There, he led a campaign against discrimination in admissions at the university's medical school.[193] His civil rights activism, however, drew attention, and when he later applied to medical schools, he found that he had been "black-balled."[194]

After working in journalism for four years, Geiger reapplied to medical school and was admitted to the Western Reserve School of Medicine in 1954. Geiger later recalled that the admission was a "fortunate choice." The school's commitment to a patient-centered approach seemed like a good fit for the socially-minded medical student.[195] At Western Reserve, Geiger was able to fuse his commitment to social justice with his interest in medicine. There, he had what he called an "epiphany":

> Standing on the steps of the medical school one day, I could see the university and the hospital, the contained environment of our health care universe. But beyond that, I could see the sprawl of urban Cleveland. It occurred to me that out there, who got sick and who stayed healthy, why the sick were ill, what happened to them next, and their interactions with us in the health care system were not just biological phenomena: they were social, political, racial, and economic phenomena as well. It was as if all my earlier life commitments to civil rights and social justice had merged with medicine, what I had embarked upon now.[196]

Believing he had "invented" social medicine, Geiger soon immersed himself in literature on the subject, only to discover that a long line of German and British thinkers had preceded him. He was disappointed, however, by the contemporary American literature, which he felt was too "touchy-feely"—more about social medicine as a general "attitude" than a firm commitment

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[193] For a more thorough account of Geiger's civil rights activism, see H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents" in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home,* eds. Anne-Emanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 106-108.

[194] Interview with Dr. Jack Geiger, February 13, 2016, Brooklyn, NY.

[195] H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents," 108.

[196] H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents," 108-109.

to its practice.[197] Looking for mentorship, Geiger contacted Warren Weaver, then the vice president at the Rockefeller Foundation, who recommended that Geiger write to Drs. Sidney and Emily Kark at the University of Natal Medical School in Durban, South Africa.[198]

In the early 1940s, the South African Health Department had hired Drs. Sidney and Emily Kark, recent graduates of the medical school at the University of Witwatersrand, to establish a health center on a Zulu reserve in the Pholela district. Located in the foothills of southwest Natal, Pholela was home to 30,000 people, most of whom belonged to a major Zulu tribal group that had been "resettled" in the area.[199] Like many "Reserve" areas, Pholela was overcrowded and plagued by problems of malnutrition and frequent epidemics. A health survey of South African schoolchildren had recently drawn attention to poor health conditions among the African populations living on these reserves, spurring the Health Department to initiate a program of health centers. Though the advent of World War II later constrained the government's efforts, the health center at Pholela managed to survive.[200]

At Pholela, the Karks pioneered a practice of community health, which they named "community-oriented primary care (COPC)." The health center included a clinic, where doctors and nurses combined curative care with preventative measures, including well-baby checkups and immunizations. The heart of the Karks' approach, however, lay in the health center's field component—a contingent of community health workers (CHWs) who served as the primary liaison between the professionals and the surrounding community. These CHWs were mostly local Zulu men and women whom the Karks trained in data gathering, epidemiology,

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[197] H. Jack Geiger, "Contesting Racism," 109.
[198] H. Jack Geiger, "Contesting Racism," 109.
[199] Sidney and Emily Kark, *Promoting Community Health: From Pholela to Jerusalem* (Johannesburg, South Africa: University of Witwatersrand Press, 1999): 22.
[200] Sidney and Emily Kark, *Promoting Community Health,* 22.

environmental hygiene, and survey methods. After a period of training, they were sent out into the "field" to canvas the community, where they conducted extensive health surveys. This information was then aggregated and synthesized to determine a "community diagnosis" that would identify the central health problems facing the community.[201] In addition to their data-collecting functions, CHWs also helped to build community gardens and latrines in an effort to root out some of the underlying environmental causes of disease. These efforts, while simple, were revolutionary for a health center, and they vastly stretched the boundaries of what was traditionally considered medical care. In this way, the Karks hoped that the clinic and the fieldwork would go hand-in-hand, each "perform[ing] complementary functions in the health centre practice." The coordination of the clinical and the epidemiological thus formed the core of what came to define COPC.[202]

It was this innovative approach that attracted international attention, including that of Weaver. With Weaver's encouragement and assistance, Geiger received a training grant from the Rockefeller Foundation to spend a portion of his final year of medical school in Durban and Pholela.[203] There, Geiger encountered the practice of social medicine for the first time—an experience which he later referred to as "life-changing."[204] While he had found much of the literature on social medicine to be vague and impractical, the Karks' health center presented a tangible, working model of how social medicine could improve the health of marginalized populations. At Pholela, Geiger learned "to practice amid what was a virtual flood of

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[201] Sidney and Emily Kark, *Promoting Community Health*, 30.
[202] Sidney and Emily Kark, *Promoting Community Health*, 31.
[203] H. Jack Geiger, "Letter to Katharine E. Oster," May 31, 1957, Box 9, Rockefeller Foundation Records, Grants, RG 10.1, Series 200E, Rockefeller Archive Center.
[204] H. Jack Geiger, "Contesting Racism," 110.

epidemiologic and demographic information."[205] He was particularly struck by the ways in which community demographics and epidemiology constantly informed clinical practice. The walls of the health center, he noted, were plastered with charts depicting the incidences of major diseases in the community.[206]

Geiger's four-month trip to South Africa not only further cemented his interest in social medicine, but it also sparked a new interest in international health. Writing to Weaver after his return to the U.S., Geiger mused that the developing world was the next frontier for social medicine, writing, "I would guess that the crucial areas now (looking 20 years or so ahead) are Asia, Africa, Latin America."[207] Geiger believed that medicine could be used as a tool of social justice, and places like Africa seemed ripe for such intervention. Although he was eager to go abroad and begin working for a philanthropic organization immediately, Weaver advised him to continue his clinical training. On Weaver's advice, Geiger completed a residency in internal medicine on the Harvard medical service at Boston City Hospital and earned a degree in epidemiology from Harvard's School of Public Health.[208]

Geiger had just completed his clinical training when he left to spend Freedom Summer in Mississippi. Although he had been working towards a career in international health, seeing the conditions in Mississippi spurred him to change his plans. He later recalled, "That month-long look at Mississippi almost immediately brought the realization that I didn't have to go to Africa, Southeast Asia, or Latin America to do our work. We had all those problems here."[209] Just as the nurse Judith Hasselberger had discovered, Geiger saw that racial segregation and poverty had

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[205] H. Jack Geiger, "Contesting Racism," 110.
[206] H. Jack Geiger, "Contesting Racism," 110.
[207] H. Jack Geiger, "Letter to Warren Weaver," January 5, 1958, Box 9, Rockefeller Foundation Records, Grants, RG 10.1, Series 200E, Rockefeller Archive Center.
[208] H. Jack Geiger, "Contesting Racism," 110.
[209] H. Jack Geiger, "Contesting Racism," 110.

created "a third world in the United States."[210] While Geiger's time in South Africa and his clinical training had taught him how medicine could be used as an "instrument of social change," Freedom Summer presented him with an opportunity to apply these convictions much closer to home.

Community Organizing for Health

As the MCHR looked to clarify its role in Mississippi, Geiger worked with Dr. Count Gibson, the director of preventative medicine at Tufts University, to develop a new strategy. The two formed the MCHR Long-Term Program and Planning Committee and searched for ways to extend the MCHR's presence in Mississippi after the Freedom Summer volunteers dispersed.[211] In a stroke of fortuitous timing, as funding from COFO and SNCC seemed to be faltering, a new civil rights organization, the Delta Ministry, stepped in and offered to fund the MCHR's work in Mississippi. The Delta Ministry had been founded in September 1964 by the National Council of Churches in an effort to bring long-term change to African Americans in Mississippi. Led by two white ministers from the northeast, the organization emphasized enacting change through community mobilization and the empowerment of local indigenous leaders. Though much of the Delta Ministry's program focused on achieving economic equality through innovative initiatives like manufacturing cooperatives, it also recognized the importance of health care in improving living conditions for African Americans.[212]

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[210] H. Jack Geiger, "A Life in Social Medicine," *The Doctor-Activist: Physicians Fighting for Social Change*, ed. Ellen L. Bassuk (New York: Plenum Press, 1996), 15.

[211] Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[212] For more on the Delta Ministry, see Mark Newman, *Divine Agitators: The Delta Ministry and Civil Rights in Mississippi* (Athens: University of Georgia Press, 2004); James F. Findlay,

The Delta Ministry's goals thus aligned with Geiger's efforts to use medicine to effect social change, and the two organizations joined forces to improve medical care in Mississippi. At a time when the MCHR's attention was increasingly turning to the direct provision of health care for African Americans in Mississippi, the support of the Delta Ministry further cemented this shift, giving the MCHR the tools and funding it needed to begin a larger-scale project. As part of its support for the MCHR, the Delta Ministry agreed to fund three public health nurses in Mississippi. With this funding, Geiger hired three white northern nurses who had served as summer volunteers for COFO—Kathy Dahl, Phyllis Cunningham, and Josephine Disparti.[213] Dahl was assigned to Holly Springs in northern Mississippi, Cunningham to Hattiesburg in southern Mississippi, and Disparti to Holmes County in the Mississippi Delta.[214]

To MCHR board member Dr. Constance Friess, the public health nurses were the "most promising portion" of the organization's program.[215] Because they worked entirely with the populations they were intended to serve, they were especially attuned to the needs of their communities. By relying on public health nurses, the MCHR could adopt a flexible approach, tailored to the needs of each community. Nurses thus formed a key link in the MCHR, connecting those working in the headquarters in NYC to the populations on the ground.

Church People in the Struggle: The National Council of Churches and the Black freedom movement, 1950-1970 (New York: Oxford University Press, 1997).

[213] John Dittmer, *The Good Doctors*, 67.

[214] Constance Friess, "Medical Committee for Human Rights—Mississippi Problems as of October 24, 1964 to November 1, 1964," page 2, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[215] Constance Friess, "Medical Committee for Human Rights—Mississippi Problems as of October 24, 1964 to November 1, 1964," page 2, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

These nurses blurred the line between health educators and community organizers.[216] In Hattiesburg, for example, Cunningham split her time between providing clinical care and mobilizing communities to push for better access to health care.[217] After spending the summer making house calls and teaching health education classes in Hattiesburg, she looked to expand her reach after being hired by the MCHR in the fall. With the help of COFO and the approval of the MCHR, Cunningham traveled across southeastern Mississippi. At each stop, she set up "semi-clinics," where she offered free medical consultations to local residents.[218] At the same time, she canvassed communities, appointing "health officers" in charge of organizing local health committees. These health committees acted as her "feelers" in the community, circulating information about her clinics and notifying her of chronically ill patients in the region. Cunningham, however, had larger goals for these committees. By organizing grassroots health committees, she hoped to build the base of a political movement. As one nurse, Cunningham realized she could not provide the necessary health care for such a vast, underserved population, but she hoped that, through the political mobilization of the population, she could begin a process that would eventually lead to greater change. For instance, by exerting community pressure on municipal authorities, these committees might be able to address issues like garbage

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[216] John Dittmer, *The Good Doctors*, 70.

[217] Dittmer, *The Good Doctors*, 70; Aaron Wells, "Letter to Phyllis Cunningham," October 14, 1964, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[218] Phyllis Cunningham, "Letter to Claire Bradley," October 12, 1964, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

disposal and sanitary privies—long-standing problems that had been the sources of disease in many poor communities.[219]

In building a movement, Cunningham tried to incorporate as much of the community as possible. In a letter to Claire Bradley, the MCHR office manager in Jackson, Cunningham worried that the movement could be controlled by self-appointed community leaders, the "same people who are always on committees for everything." Instead, she hoped to "catch some of these 'fringe people'" so that the health committees could truly represent the interests of the entire community.[220] However, her efforts were hampered by the size of the region she was expected to cover. Vicki Levi, a medical student at Albert Einstein College of Medicine who worked with both Disparti and Cunningham, wrote in a report that, while Cunningham had "a real rapport with the community," she had "difficulty in getting any program underway because she [had] to travel from one town to another—in a sort of travelling salesman fashion."[221]

While Cunningham crisscrossed southeastern Mississippi trying to mobilize a movement, Josephine Disparti was working cautiously yet steadily to lay the groundwork for community participation in Holmes County. Holmes County presented a unique challenge. One of the poorest counties in Mississippi, it had little medical infrastructure. There were no black doctors in the county, and plantation owners often dictated what medical services their sharecroppers

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[219] Phyllis Cunningham, "Letter to Claire Bradley," October 12, 1964, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[220] Phyllis Cunningham, "Letter to Claire Bradley," October 12, 1964, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[221] Vicki Levi, "Report on Activities in Mississippi," March 1965, page 2, Folder 335, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

received.[222] Furthermore, while the region was home to a strong, indigenous civil rights movement, that movement was often hostile to outsiders.[223] Local black leaders resented the intrusion of COFO and ultimately forced COFO to move its headquarters to the outskirts of the county.[224] Disparti was thus in a difficult position, since, in order to work in Holmes County effectively, she needed to distance herself from COFO. However, without this institutional support, Disparti found herself isolated—a nurse "with no backup." Making house calls alone as a white outsider was difficult and dangerous. Visiting sharecroppers in their homes, for example, meant trespassing on the property of white owners. To avoid detection, Disparti would sometimes lie on the floor of the car, wearing a bandana to cover her hair.[225]

Singlehandedly trying to provide medical care to an entire county, Disparti chose a new community center in Mileston as her base. Mileston, a tiny hamlet in the Delta, was unique. In the 1930s, the New Deal's Farm Security Administration program had allowed black farmers to purchase small farms in the area, and by the 1960s the town had become an important haven for civil rights activists in the Mississippi Delta.[226] The new community center, built by a northern philanthropist, soon became a hub for the local movement. As the "largest indoor area available

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[222] John Dittmer, *The Good Doctors*, 74.

[223] The civil rights activist Lawrence Guyot said that no other local movement in Mississippi was "as broad based, indigenous, or as contagious as in Holmes." John Dittmer, Foreword to *Thunder of Freedom: Black Leadership and the Transformation of 1960s Mississippi*, by Susan Hasalo Sojourner and Cheryl Riana Reitan (Lexington: The University Press of Kentucky, 2013), xii.

[224] John Dittmer, *The Good Doctors*, 75.

[225] John Dittmer, *The Good Doctors*, 74-75.

[226] Akinyele K. Umoja, "1964: The Beginning of the End of Nonviolence in the Mississippi Freedom Movement." *Radical History Review* 85, no. 1 (2003): 212-213.

in the county for blacks to use," the center provided a natural space for community meetings, social events, and welfare programs.[227]

Hearing about Disparti's work at the Mileston clinic, Geiger was immediately intrigued. He had been searching for ways for the MCHR to establish a permanent presence in Mississippi, and he envisioned a nurse-operated clinic as a promising base for a new form of intervention in Mississippi health care. With the help of two philanthropists, Luke and Ruth Wilson, Geiger secured funding for a clinic and charged Disparti with laying the groundwork for the new project.[228]

Both Cunningham and Disparti were initially skeptical of Geiger's plans to build a clinic. Experience in mobilizing the local communities had made them wary of any kind of top-down intervention. In a letter to Aaron Wells, the national chairman of MCHR, Cunningham wrote that the MCHR's greatest obstacle in effecting change in Mississippi was its own top-down hierarchy, with most high-ranking officials residing at the headquarters in New York City . An organization based there, she argued, would not be able to run the day-to-day operations of a clinic in Mississippi. The only way such a program would work would be "if the set-up [was] taken over by the community and really a community project."[229]

Disparti echoed these concerns. After patiently building trust in the community, she worried that a major intervention might disrupt the balance she had worked so carefully to achieve. Though she agreed to Geiger's plan for a clinic, she also cautioned him to move slowly.

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[227] Susan Hasalo Sojourner and Cheryl Riana Reitan, *Thunder of Freedom: Black Leadership and the Transformation of 1960 Mississippi* (Lexington: The University Press of Kentucky, 2013), 56, 70.

[228] John Dittmer, *The Good Doctors*, 75.

[229] Phyllis Cunningham, "Letter to Aaron Wells," October 21, 1964, Folder 334, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

When the Delta Ministry donated the funds for a "Healthmobile"—a Ford Ecoline van that would act as a clinic on wheels—Disparti suggested waiting until the community was ready to introduce the vehicle.[230] Instead, she began the slow work of organizing a health association, canvassing door-to-door and even in the cotton fields during the harvesting season. Disparti hoped that a health association representing the community would be able to articulate local health problems and eventually to help run the clinic.[231] Such an association, she said should "generally represent the community voice and forces."[232] At the same time, she hired local teenagers to help set up the clinic site in two rooms of the community center, installing equipment and stocking the cabinets with first-aid supplies.[233]

Disparti's organizing made steady progress. While the health association started with only eight members, it gradually gained momentum. Within three months, the Holmes County Health Improvement Association was meeting weekly in the community center—a "fair-sized group of local people interested in health issues, classes, and improving their families' lives."[234] Many in MCHR were impressed by Disparti's ability to mobilize community participation.

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[230] John Dittmer, *The Good Doctors*, 76.

[231] Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[232] Josephine Disparti, "Report on Holmes County Community Health Program," November 23, 1964, Folder 130, Box 13, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[233] Susan Hasalo Sojourner and Cheryl Riana Reitan, *Thunder of Freedom: Black Leadership and the Transformation of 1960 Mississippi* (Lexington: The University Press of Kentucky, 2013), 76.

[234] Josephine Disparti, "Report on Holmes County Community Health Program," November 23, 1964, Folder 130, Box 13; Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania; Susan Hasalo Sojourner and Cheryl Riana Reitan, *Thunder of Freedom: Black Leadership and the Transformation of 1960 Mississippi* (Lexington: The University Press of Kentucky, 2013), 76.

After working alongside Disparti, Vicki Levi wrote, "I was continually struck by the fact that acceptance by the community and effectiveness in arousing participation was in direct proportion to the time spent by public health nurses living in one community and slowly getting to know the people. I think this is dramatic in Mileston where Jo has really learned the gift of listening and allowing people to articulate for themselves their needs—with direction, of course—but the day-to-day slow but consistent contact appears to be effective."[235]

Although Disparti had initially shied from any official political involvement, her time in Mileston convinced her that providing medical care was not enough. To effectively treat the health issues of the community, racial segregation had to be confronted and dismantled. She increasingly came to believe that the Health Association could have an impact beyond the clinic as a political organization. She encouraged Health Association members, for example, to document discrimination they encountered from medical institutions and helped them file formal complaints with the U.S. Department of Health, Education, and Welfare.[236] As the Health Association evolved, it blurred the line between medical and political, becoming increasingly embedded in the civil rights movement.

As Disparti continued to organize local communities, the MCHR worked to build a small staff to support the new clinic. In July 1965, the MCHR hired two African-American nurses, Helene Richardson and Patricia Weatherly, who worked with the Health Association to determine how the clinic could best address the health needs of the community. Together, they designed a program that focused on diagnosing, screening, and prevention. As much as possible,

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[235] Vicki Levi, "Report on Activities in Mississippi," March 1965, page 2, Folder 335, Box 31, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[236] Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

the nurses tried to defer to the community's requests. For instance, while they had envisioned a health education series that dealt with issues like diabetes and venereal diseases, they were surprised when many mothers asked instead for practical lessons in how to treat children's insect bites and burns.[237] This process of community organization and participation took time. Although the Health Association was active by the end of the year, it was not until November 1965 that the Irving W. Winik Memorial clinic—named to commemorate an activist D.C. physician—officially opened its doors.[238]

Disparti left Mississippi in the fall of 1965, but the clinic persevered and even thrived in her absence. Looking back a year later, the nurses credited the emphasis on community participation with the clinic's success: "As part of our work we encouraged the people to gather to share problems and discuss programs and action that might lead to better health, medical, and welfare conditions. We found that it is important at first to listen to all concerns of the people and not to turn a deaf ear if the conversation does not concern health matters."[239] In actively mobilizing, organizing, and empowering the community, these nurses pioneered the MCHR's first experiment in community participation in health care.

Thus, the concept of community engagement was not a policy issued from MCHR headquarters. Rather, it emerged out of the exigencies of the situation on the ground. In the most basic sense, it solved a practical need. Outside of its office in Jackson, the MCHR had only a thin presence in Mississippi, and without community involvement the handful of nurses would

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[237] M. Phyllis Cunningham, Helene Richardson Sanders, and Patricia Weatherly, "We Went to Mississippi," *The American Journal of Nursing* 67, no. 4 (1967): 803.

[238] Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.

[239] M. Phyllis Cunningham, Helene Richardson Sanders, and Patricia Weatherly, "We Went to Mississippi," *The American Journal of Nursing* 67, no. 4 (1967): 803.

not have been able to run the day-to-day operations of a clinic. Furthermore, nurses like Disparti and Cunningham found community participation to be an effective method of navigating a complex political landscape hostile to outside intervention. But community participation also resonated on a deeper level. After spending time in Mississippi, Disparti was "forced to conclude" that "true change in the health of the Negro, and the poor in general, would come only when they obtain full political freedom."[240] In the midst of civil rights ferment, it was impossible to separate the medical and the political. Community participation seemed to be a way to unite these dual goals—to achieve better health care while also working towards broader political empowerment.

A Community Health Center for Mississippi

In December 1964, as Cunningham continued to canvas Hattiesburg and Disparti organized the Health Association in Holmes County, MCHR delegates, including Geiger, met with Art Thomas and Warren McKenna of the Delta Ministry to discuss the future of their health care work in Mississippi. Frustrated with the slow progress of the MCHR's efforts in the state and anxious to develop a plan for a larger-scale intervention, McKenna and Thomas asked if the Mileston could be the basis of a larger program across the state. Geiger expressed skepticism, telling them that Mileston was "an incomplete idea and it wasn't replicable."[241] After all, the Mileston clinic had relied on a one-time donation from outside philanthropists. For a larger scale intervention, a more stable source of funding would have to be found. As the group pondered alternative ways to address the health of the poor in Mississippi, Geiger remembered his

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[240] Helene Richardson and Patricia Weatherly, "Holmes County Clinic: An Experiment in Rural Health Care," Folder 340, Box 32, Medical Committee for Human Rights Records, Kislak Center for Special Collections, Rare Books and Manuscripts, University of Pennsylvania.
[241] John Dittmer, *The Good Doctors*, 82.

experience working for the Karks in South Africa. Although he had been working with the public health nurses to develop strategies for community participation, he had not consciously connected this work to the community-oriented primary care he had observed in South Africa. Years later, he remembered how, meeting with the Delta Ministry, he suddenly "explicitly recalled Pholela and the University of Natal" and exclaimed, "What we really need is a good northern medical school to come down and sponsor a comprehensive community health center to practice community-oriented primary care!"[242]

Geiger's suggestion immediately received attention from his colleagues, and he explained the Karks' model in detail. Dr. Robert Smith and Dr. Desmond Callan, both of whom had been working with the MCHR in Mississippi, expressed enthusiastic support of the idea. Though he had proposed the idea, Geiger thought the proposal was mostly a "pipe dream" until he spoke with Dr. Count Gibson after the meeting. Gibson, then the chair of the Department of Preventative Medicine at Tufts Medical School, approached Geiger and told him, "If you can find the money, Tufts Medical School will sponsor it."[243]

Geiger's proposal at the meeting with the Delta Ministry is often considered the origin point of the community health movement. Such histories, however, overlook the groundwork that doctors (including Geiger himself), nurses, and civil rights organizers laid in Mississippi. While Geiger consciously based his model for community health on the Kark's model of community-oriented primary care, the idea of "community" he promoted was not simply imported from South Africa. Rather, his understanding of community had been fundamentally shaped by the civil rights movement and the work of MCHR nurses on the ground in Mississippi. The Karks' model of COPC, like the community health that Dr. Deuschle and Dr. McDermott

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[242] H. Jack Geiger, "Contesting Racism," 111.
[243] H. Jack Geiger, "Contesting Racism," 111.

had promoted in the 1950s and early 1960s, was based on an understanding of community that was fundamentally epidemiological. Freedom Summer, however, had blurred the distinctions between "activist" and "medical professional" and imbued "community" with a new set of implications. By the time Geiger spoke to the Delta Ministry in December 1964, community was as much a political term as it was a medical one. For civil rights activists, "community" was inseparable from ideas about political empowerment and grassroots leadership.

CHAPTER 3

Community Action Meets Community Health:

A New Model for Health Care

In late 1964, searching for a source of funding for a community health center, Dr. Jack Geiger approached William Kissick, a physician in the Surgeon General's office at the Department of Health, Education, and Welfare (HEW). Kissick, one of the architects of Medicare, was intrigued by Geiger's idea but felt that HEW would not be a good fit for the program. Instead, Kissick contacted Lisbeth Bamberger, who had just been hired to head the health division of the newly formed Office of Economic Opportunity (OEO). As Bamberger later recalled in her book, *Within Our Reach*, Kissick called and explained, "Hey Lee, there's a wild man in my office, and he's got some ideas we can't do much with over here, but I think you people in the War on Poverty would find him pretty interesting."[244] Bamberger met Geiger and referred him to her boss, Sanford Kravitz, the head of the OEO's research and demonstrations unit.

The following January, in what he later called a "classic example of academic faint-heartedness," Geiger asked Kravitz for $30,000 to conduct a "feasibility study" to test the possibility of a community health center. Kravitz, however, denied him, saying "You can't have that […] You have to take $300,000 and do it now."[245] Startled by this response, Geiger returned to Boston, where he and Dr. Count Gibson hurried to draft a more comprehensive proposal for

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[244] Lisbeth B. Schorr, *Within Our Reach: Breaking the Cycle of Disadvantage* (New York: Anchor Books, 1989), 130-131.

[245] H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents" in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home,* eds. Anne-Emanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 112.

the OEO. Weeks later, the two returned to Kravitz with a drastically expanded proposal and a revised budget totaling $1.3 million. According to this new plan, Tufts would sponsor two community health centers—one in a still to-be-decided location in the South and one at Columbia Point Housing Project, a low-income housing complex on the outskirts of Boston.[246]

Officially approved by Sargent Shriver, the head of OEO, in June 1965, the Tufts proposal was the first of many community health center proposals funded by the agency.[247] In a short time, an idea that had seemed to be a "pipe dream" to medical reformers and civil rights activists had become the basis of a federal social program.[248] Histories of the community health centers tend to present the program either as a top-down expression of the OEO's "community action" impetus or as the brainchild of medical reformers and activists like Geiger and Gibson.[249] This chapter takes a different tack. Instead of taking OEO support for the health center program for granted, it looks at why the OEO was so receptive to community medicine proposals. The community health center program was able to take off because the proposed model resonated with concurrent developments in poverty policy. The idea of community medicine had been brewing among medical reformers and civil rights activists for some time, and federal policymakers had been exploring "community action" as a possible solution to poverty in the U.S. Thus, searching for community-based solutions, the OEO proved to be an eager audience for Geiger and Gibson's proposal.

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[246] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick: Rutgers University Press, 2007), 8.
[247] Bonnie Lefkowitz, *Community Health* Centers, 9.
[248] H. Jack Geiger, "Contesting Racism," 111.
[249] Bonnie Lefkowitz's *Community Health Centers*, one of the few books to focus on the community health center program, comes the closest to uniting the two perspectives, but Lefkowitz only devotes part of her first chapter to the OEO, which then quickly falls out of the main narrative.

In his intellectual history of the Progressive Era, *Atlantic Crossings*, the historian Daniel Rodgers writes that the Great Depression, like other major crises, generated an "opportunism of expediency." As policymakers scrambled for solutions, they turned to the policy ideas of the previous generation of Progressive reformers.[250] While the 1960s were not a crisis in the same sense as the Great Depression, the rushed nature of the early days of the War on Poverty produced a similar effect, providing the political impetus necessary to turn "old" ideas into new social policy. For a brief moment in the early days of the War on Poverty, funding was plentiful and speed was imperative. As the OEO rushed to solicit proposals for programs, medical reformers were able to seize the opportunity to gain federal support. The "opportunism of expediency" thus allowed community medicine—an idea otherwise relegated to small circles of reformers—to become part of a nationwide social program.

The War on Poverty and the Lure of Community Action

Geiger had arrived in D.C. at an opportune moment. The War on Poverty, inaugurated by President Johnson in 1964, had initiated a frenzied search for legislative solutions to poverty. Community action proved attractive to these federal policymakers, becoming a buzzword among them almost overnight. At the same time, however, community action was also nebulous. Few at the time knew what the implementation of the concept would look like or how it could form the basis of a poverty program.

Community action entered the political lexicon in the early 1960s in response to changing conceptions of poverty and a growing sense of an urban crisis. Over the previous two decades, millions of African Americans had moved from the rural South to the urban North. The shifting

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[250] Daniel Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge: The Belknap Press of Harvard University Press, 1998), 414.

demographics had garnered little attention in the 1950s. Most public policy experts subscribed to a consensus view of American society that maintained that the country had largely overcome its racial problems.[251] Still, by the 1960s, dissent was beginning to emerge, albeit only on the fringes of liberal intellectual circles.[252] In remote corners of the government, universities, and foundations, intellectuals launched new inquiries into the state of the urban ghetto. One of these corners was located in the Ford Foundation. In 1961, the Ford Foundation started a series of experiments in urban renewal, dubbed the Gray Areas program, to address what they saw as the rising problem of urban ghettoes. Though the Ford Foundation shrunk from explicitly invoking race, it was common knowledge that "Gray Areas was a euphemism for black areas."[253]

On the surface, the Gray Areas program did not seem particularly pioneering. Community-based social work was nothing new, and many of the programs seemed to be descendants of a longer tradition dating back to the settlement houses of the Progressive Era. But some Gray Areas programs distinguished themselves. One of the most innovative was the Mobilization for Youth, an organization on the Lower East Side of New York City that promised to mount "a 'saturation' campaign against delinquency."[254]

Initially sponsored by settlement houses, in the early 1960s the organization partnered with two prominent sociologists at the Columbia University School of Social Work—Richard

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[251] John Kenneth Galbraith's 1958 book, *The Affluent Society*, for instance largely ignores race, mentioning it in passing only once. Nicholas Lemann, *The Promised Land: The Great Black Migration and How It Changed America* (New York: Vintage Books, 1991), 117.

[252] In 1955, when Leonard Duhl, a psychologist at the National Institute of Mental Health, put together a team of experts to study urban areas and challenge dominant theories of urban renewal, their ideas were so far outside the mainstream that he dubbed the group the "Space Cadets." Nicholas Lemann, *The Promised* Land, 118-119.

[253] Nicholas Lemann, *The Promised* Land, 119.

[254] For more on the Gray Areas program and the roots of community action, see Alice O'Connor, "Community Action, Urban Reform, and the Fight against Poverty: The Ford Foundation's Gray Areas Program," *Journal of Urban History* 22, no. 5 (1996): 586-625.

Cloward and Lloyd Ohlin.[255] These sociologists, who had spent the past few years studying delinquency, were able to provide the organization with "something a little more theoretically glitzy" than the traditional social work approach.[256] Cloward and Ohlin envisioned Mobilization for Youth as a way to put into practice the "opportunity theory" they had articulated in their 1960 book, *Delinquency and Opportunity*. According to opportunity theory, delinquency was a rational choice. Faced with few "legitimate" avenues for success, lower-class boys turned to "illegitimate 'structures of opportunity.'"[257] Cloward and Ohlin thus hoped that Mobilization for Youth could address the systematic causes of delinquency by creating community services that would provide opportunities for low-income youth.[258]

Community empowerment soon emerged as the key to unlocking this vicious circle. If the delinquency problem was a systematic one, rather than an individual deficiency, then it logically followed that widespread change was needed to root out the underlying problem. In order to effect this change, they concluded, it would first be necessary to empower the community. According to Nicholas Lemann, Cloward and Ohlin saw political empowerment and economic advancement as closely intertwined. Governing their approach was the theory that "poverty is more a political than an economic condition and that if the poor become politically 'empowered,' they will soon cease to be poor. Empowerment would give poor people a new spirit of community, they would run their own lives, and their neighborhoods, with renewed purposiveness and vigor, and they would learn to get things from the powers that be."[259]

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[255] Alice O'Connor, *Poverty Knowledge: Social Science, Social Policy, and the Poor in Twentieth-Century U.S. History* (Princeton: Princeton, 2001), 128-129.
[256] Nicholas Lemann, *The Promised* Land, 122.
[257] Alice O'Connor, *Poverty Knowledge*, 128.
[258] Alice O'Connor, *Poverty Knowledge*, 128.
[259] Nicholas Lemann, *The Promised* Land, 122.

Although these early experiments in community empowerment had limited geographic scope, the ideas underlying them quickly made their way into federal policy, coalescing first in a somewhat surprising place—"the office of the proud holder of the number-one job in the American law enforcement hierarchy, Robert Kennedy."[260] In 1961, The President's Committee on Juvenile Delinquency had been established under Attorney General Robert F. Kennedy's Justice Department to deal with a perceived rise in "youth crime." However, under the purview of David Hackett, a close friend of Kennedy's, the Committee expanded its scope to tackle much broader problems of urban poverty, becoming known as "the government agency with the black-ghetto portfolio."[261] Soon, the Committee's work was overlapping the Ford Foundation's programs, as Hackett provided funding to many of the same programs as the Gray Areas program. Lloyd Ohlin and his colleague Richard Boone became advisers to the Committee, further solidifying the growing ties between the federal government and the private foundations and facilitating the transfer of ideas between the two. In the process, discussions of "indigenous participation" and "community competence" were condensed into the shorthand of "community action."[262]

At the same time that the Committee was experimenting with community-based solutions to juvenile delinquency, President Kennedy's Council of Economic Advisers (CEA) was drawing up a new antipoverty program in anticipation of the 1964 campaign. Led by the economist Walter Heller, the CEA was struggling to develop an antipoverty strategy. Most of its economic program revolved around a central proposition—promoting growth—but Heller realized that he would need to satisfy the critics who argued that a strategy of growth alone

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[260] Nicholas Lemann, *The Promised* Land, 123.
[261] Nicholas Lemann, *The Promised* Land, 123-124.
[262] Alice O'Connor, *Poverty Knowledge*, 127.

would not adequately address the problems of the poor.[263] Meeting with Hackett and Boone in the fall of 1963, Heller was struck by the possibilities of their community action idea. Later, he recalled, "Community action appealed to me immediately…The *moment* I heard about it, it became part of my thinking."[264] To Heller and his colleagues at the CEA, community action presented a possible solution, one that could address the most intractable kinds of poverty. It would be a solution for those at the margins—not a revolution.

Kennedy's assassination later that fall and Johnson's subsequent succession to the presidency rocketed community action to the center of federal policy. The day after assuming the presidency, Johnson was briefed by Heller on community action and the anti-poverty strategy. He immediately approved, dubbing it "my kind of program."[265] Johnson wasted little time turning the program into a fully-fledged crusade. The next January, he recruited Sargent Shriver, Kennedy's brother-in-law and the first director of the Peace Corps, to head the War on Poverty Task Force. Several months later, the task force produced a massive antipoverty bill, the legislative answer to Johnson's call for an "unconditional War on Poverty."

The Economic Opportunity Act, passed by Congress in August 1964, created a host of new antipoverty programs and established the OEO within the Executive Office of the President to coordinate them. While the law included funding for a jobs program (Job Corps) and a domestic version of the Peace Corps (VISTA), its centerpiece was the Community Action Program. Title II of the Economic Opportunity Act called for the federal government to "provide stimulation and incentive for urban and rural communities to mobilize their resources to combat poverty through community action programs." Most notably, Title II required these programs to

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[263] O'Connor, *Poverty Knowledge*, 139.

[264] Nicholas Lemann, *The Promised* Land, 133.

[265] Nicholas Lemann, *The Promised* Land, 141.

be “developed, conducted, and administered with the maximum feasible participation of residents of the areas and members of the groups served.”[266] The phrase “maximum feasible participation” was the first attempt to operationalize community action and to pinpoint what constituted a community action program.

There was little agreement, however, on what exactly community action was. In his collection of oral histories, *Launching the War on Poverty*, Michael Gillette points out that, even in hindsight, policymakers who had been involved in the creation of community action programs never quite agreed on the origins or definition of the term. Shriver, for instance, believed that a community action agency would act like a local school board, and he envisioned a cross-section of community members operating with an independent status. Others, however, clung to more narrow visions of community action, insisting that community action was meant as a way for more traditional social services to improve their “customer relations.”[267]

Perhaps more surprising than the differences among the policymakers, however, is the lack of debate at the Congressional level. Given the later controversies surrounding the OEO and its community action programs, it is remarkable how few legislators sought to clarify what “community action” meant in the summer of 1964. Even the phrase “maximum feasible participation,” which soon became one of the most distinctive—and controversial—legacies of the War on Poverty, appears to have engendered little debate at the time. In a 1969 article on community action, the sociologist Lillian B. Rubin noted that the phrase received almost no attention from Congress while the bill was being debated. “With the exception of the statement by then Attorney General Robert F. Kennedy,” she reported, “there is no mention of the clause in

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[266] Sec. 202, 78 Stat. 516, 42 U.S.C. § 2782 (1964),

[267] Michael L. Gillette, *Launching the War on Poverty: An Oral History*, 2nd ed. (New York: Oxford University Press, 2010), 81, 90-91.

several thousand pages of testimony."[268] Despite these ambiguities—or perhaps because of them—community action gained widespread acceptance. What had been viewed as a marginal experiment soon became the basis for a nationwide "unconditional war on poverty."[269] Community action was suddenly everywhere.

For policymakers searching for an antipoverty strategy, community action had immediate appeal. Policymakers had not yet begun to unravel the messy implications of the doctrine. In fact, what drew these early adopters to the concept was its seeming simplicity—the way it neatly linked economic and political empowerment and suggested that multiple complicated social issues could be addressed in tandem. According to Alice O'Connor, policymakers were attracted by the seeming comprehensiveness of the idea: "The architects of these community action experiments were themselves in search of an overarching framework for their varied efforts, a 'unified program' that would get to the 'root causes' of these interconnected social problems."[270]

Community action had other attractions as well. It was a heady time to be a policymaker in the federal government, and community action was a novel solution that articulated growing dissatisfaction with traditional bureaucratic solutions. The general sense that traditional welfare was unsustainable and undesirable had been brewing for years.[271] In 1962, President Kennedy had promised to reform Aid to Dependent Children (ADC), whose relief rolls seemed to be

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[268] Lillian B. Rubin, "Maximum Feasible Participation: The Origins, Implications, and Present Status," *The Annals of the American Academy of Political and Social Science* 385, no. 1 (1969): 15.

[269] Michael L. Gillette, *Launching the War on Poverty: An Oral History*, 2nd ed. (New York: Oxford University Press, 2010), xvii.

[270] Nicholas Lemann, *The Promised Land*, 159.

[271] Michael B. Katz, *The Undeserving Poor: America's Enduring Confrontation with Poverty*, 2nd ed. (New York: Oxford University Press, 2013).

constantly expanding, and move towards an emphasis on "rehabilitation."[272] Kennedy's advisers at the CEA blamed "politics of bureaucratic self-interest" for much of the inefficiency of social welfare programs. Federal agencies, they argued, proposed solutions that benefited themselves first and the public good second, creating an ever-increasing "dole" that merely perpetuated poverty.[273] In contrast, community action was a fresh alternative, not yet sullied by the endless back and forth between old-line federal agencies.

Finally, community action seemed to provide certain strategic advantages. Recent battles over civil rights for African Americas had put the federal government at odds with state governments in the South, and federal policymakers were wary of any policy solution that required the approval of the states. Worried that their efforts would be undone by obstructionist Southern politicians, policymakers turned to community action as a way to circumvent these obstacles.[274] Unlike ADC and other welfare programs, in which money trickled down through a hierarchy of state and local officials, community action programs would provide money to community action agencies directly. Although Southern Democrats managed to amend the bill to allow governors to veto community action programs in their state, any veto could be overridden at the will of the OEO director.[275] By promising to establish a channel connecting the federal

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[272] Gareth Davies, "War on Dependency: Liberal Individualism and the Economic Opportunity Act of 1964" *Journal of American Studies* 26, no. 02 (1992): 210.
[273] O'Connor, *Poverty Knowledge*, 155.
[274] In *Liberty and Coercion,* Gary Gerstle writes that "among the federal government's intentions in launching the War on Poverty was the undermining of the independent power of states and municipalities as well as the oligarchs who allegedly ran most of them." Gary Gerstle, *Liberty and Coercion: The Paradox of American Government from the Founding to the Present* (Princeton: Princeton University Press, 2015), 308.
[275] Martha J. Bailey and Nicolas J. Duquette, "How Johnson Fought the War on Poverty: The Economics and Politics of Funding at the Office of Economic Opportunity." *The Journal of Economic History* 74, no. 02 (2014): 357.

government with local communities, community action resonated with broader desires to contain and restrict the power of the states.[276]

Thus, as Nicholas Lemann writes, "Like supply-side economics in the 1980s, maximum feasible participation was a new and untested idea that, because it happened to hit Washington at a propitious moment, overnight became a sweeping national policy."[277] By the fall of 1964, community action and its legislative counterpart, maximum feasible participation, had become the basis of a major national antipoverty strategy. But it was still unclear how they could be translated into practice. This task fell to the brand-new Office of Economic Opportunity.

The OEO: A "Heroic Bureaucracy"?

The Economic Opportunity Act was largely a piece of enabling legislation, providing for a vast new spate of antipoverty programs and authorizing the OEO to run these programs without giving details about how these new programs were to operate. Furthermore, as part of the executive office of the president, the OEO was free of many traditional bureaucratic restraints. Essentially, a handful of OEO administrators were charged with determining the course of the War on Poverty, deciding which programs to fund and determining the guidelines these programs would follow.[278]

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[276] Early advocates for community action, however, had little sense of how much backlash the policy would engender. For example, though they envisioned a few angry Southern governors, they never imagined the response they would soon receive from Northern cities, whose mayors saw CAP as a threat to their power. Nicholas Lemann, *The Promised* Land, 153.

[277] Nicholas Lemann, *The Promised* Land, 147.

[278] "Community action" may have received little attention in Congress, but the latitude given to the OEO was carefully scrutinized by opponents of the act. Republican Robert Taft Jr. of Ohio, for example, remarked, "This attack which we are supposed to be launching upon poverty would allow the director to do as he pleased […] There's actually no requirement that the director consult with anyone, other than to find a local agency of some sort, public or private, which would be willing to go along. If he did not have one available, he could create one." Martha J. Bailey and Nicolas J. Duquette, "How Johnson Fought the War on Poverty: The Economics and

The political scientist Richard Couto has argued that the OEO constituted a "heroic bureaucracy." Whereas traditional bureaucracies are primarily interested in their own self-preservation, "heroic bureaucracies" search for creative solutions that will eliminate the need for the bureaucracy altogether.[279] Regardless of whether Couto's classification scheme survives scrutiny, his terminology certainly encapsulates the spirit of the OEO's first few years.[280] Founded on the notion that poverty was a surmountable social problem, the OEO eschewed traditional bureaucracy and self-consciously styled its own work in contrast to what it perceived as the "human filing cabinets" of bureaucracies like HEW.[281] Many OEO staffers believed that they were fundamentally reconceptualizing the role of the government, summing up their mission by saying, "I'm trying to work myself out of a job"[282] This spirit—and a sense that they were breaking new ground—infused much of their work.

This spirit of "antibureaucracy" pervaded the highest levels of the agency.[283] Shriver had been Johnson's top pick for head of the OEO, and he took over the agency while still maintaining his position as director of the Peace Corps. Driven by an expansive vision of the OEO, Shriver was "intolerant of bureaucratic types." According to his colleague Donald Baker, who served as

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Politics of Funding at the Office of Economic Opportunity," *The Journal of Economic History* 74, no. 02 (2014): 357.

[279] Couto borrows the term from Isabel Marcus, who uses it to describe the OEO in her book, *Dollars for Reform.* Richard A. Couto, "Heroic Bureaucracies," *Administration & Society* 23, no. 1 (1991): 133; Isabel Marcus, *Dollars for Reform: The OEO Neighborhood Health Centers* (Lexington: Lexington Books, 1981).

[280] Couto defines heroic bureaucracies by their outcomes: heroic bureaucracies, he argues, result in a "new distribution of benefits to a group that did not have them before." I am skeptical of Couto's definition, which seems to rely heavily upon a black-and-white division between "heroic" and "traditional" bureaucracies. However, I think the term is useful in that it accurately summarizes how the OEO imagined itself. "Heroic Bureaucracies," *Administration & Society* 23, no. 1 (1991): 126.

[281] Interview with Sarah Atkeison, Albuquerque, New Mexico, June 26, 2016.

[282] Bonnie Lefkowitz, *Community Health* Centers, 3.

[283] Bonnie Lefkowitz, *Community Health* Centers, 3.

general counsel for the OEO, Shriver craved innovation: "He was never so happy as when he was talking with a bunch of people, trying to develop a new idea."[284] In populating the OEO, Shriver generally avoided career civil servant types, recruiting instead from the Peace Corps and the AFL-CIO.

To head the Community Action Program, Shriver chose Jack Conway, the director for industrial unions at the AFL-CIO. Conway then put Sanford Kravitz, a social worker with a Ph.D. in public policy, in charge of the research and demonstrations unit. Having worked as program director for the juvenile delinquency group under Robert Kennedy, Kravitz arrived at the OEO already firmly committed to the principles of community action. The research and demonstrations program, however, was a bit of an anomaly. Though part of the community action division and similarly committed to principles of "maximum feasible participation," the research and demonstrations program allowed OEO officials to circumvent the community action agencies and test "innovative programs that might not well up from the community level but that, ideally after a period of experimentation and evaluation, might provide models that could be replicated elsewhere."[285] Kravitz's position thus gave him enormous latitude in experimenting with new ideas and, ultimately, defining the boundaries of "community action."

A "research and demonstration" unit may have suggested a slow and steady approach, in which ideas were tested, extensively monitored, and then replicated. Indeed, Kravitz initially envisioned outside review committees that would evaluate each proposal. Time pressures on the OEO, however, effectively precluded such an approach. Newly flush with federal money, the OEO needed to act quickly. Anxious to start funding proposals immediately, Shriver nixed Kravitz's suggestion of outside evaluation, telling him, "You're supposed to be smart, you have a

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[284] Michael L. Gillette, *Launching the War on Poverty,* 191.
[285] Alice O'Connor, *Poverty Knowledge,* 170.

Ph.D., you bring me the proposals and I'll make the decisions." Shriver's directive ignited a "whirlwind effort" as Kravitz and his new colleagues scrambled to collect proposals.[286] Donald Baker, who served as General Counsel for the OEO, explained, "[The OEO] was a wild sort of operation in those early days. […] We didn't have any guidelines and didn't have the time really to draft them to start out […] and what, in effect, happened was that we used those original applications as a means of learning, little laboratory experiments in which we would study and decide what our policies were going to be."[287]

Most of the early proposals were disappointingly traditional. The OEO was eagerly searching for "new ways to address old problems," but, as Lisbeth Bamberger recalled, most of the proposals they received were requests to fund social services that, in their eyes, had failed to produce real reform. In contrast, Geiger and Gibson's proposal seemed both innovative and ambitious and "struck a responsive chord" in the agency.[288] Geiger and Gibson's idea had little to do with the community action of the Economic Opportunity Act. They were not the intellectual disciples of the Ford Foundation or Mobilization for Youth or the President's Committee on Juvenile Delinquency. Their community health center had emerged from a community-based approach to epidemiology, the political exigencies of the civil rights movement, and the needs on the ground in Mississippi. But Kravitz and Shriver were not ideological purists and, besides, community action had never been a single, cohesive doctrine. From Kravitz's perspective, Geiger must have appeared at a fortuitous moment. Just as Kravitz was searching for community-based poverty solutions, Geiger arrived with a proposal for a "community health center" that promised to bring health care to the poor. Kravitz recognized the

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[286] Alice O'Connor, *Poverty* Knowledge, 170.
[287] Michael L. Gillette, *Launching the War on Poverty*, 239.
[288] Lisbeth B. Schorr, *Within Our Reach,* 131.

potential in the idea. Under pressure from Shriver to fund proposals as quickly as possible, Kravitz discarded Geiger's suggestion of a "feasibility study" and pushed instead for a more comprehensive proposal so that work on the program could begin immediately.

Building a Community Health Center

On June 11, 1965, the OEO approved Geiger's plans for two community health centers. The center at Columbia Point was the first to open.[289] A low-income housing community with 6,000 residents, Columbia Point was a self-contained community that seemed ideal for such a project. Though it was only a few miles from major hospitals, it was cut off from these and the rest of the city by two major highways. This location, combined with a lack of public transportation, meant that Columbia Point residents had only limited access to health care.[290]

Under the aegis of Tufts' Department of Community Health and Social Medicine (previously the Department of Preventative Medicine), Geiger hired Josephine Disparti, the MCHR nurse who had spent Freedom Summer in Holmes County, Mississippi, to help with the health center's early stages. Disparti took on the role of community organizer, going door-to-door in the housing complex and listening to residents' concerns and ideas.[291] Over the next few months, Disparti assembled a health association modeled on the one she had established in Holmes County. Intended to act as a collective voice for the residents, the Columbia Point Health Association was the first attempt to grapple with the notion of community involvement.

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[289] On why they chose to open a health center at Columbia Point, Geiger later said, "Count and I realized that if Tufts went to Mississippi we were sure to be asked what we were doing 1,500 miles away from home when there were sorely neglected black neighborhoods close to home. We decided to try for a site in Boston as well." Bonnie Lefkowitz, *Community Health* Centers, 52.

[290] H. Jack Geiger, "Of the Poor, By the Poor, or For the Poor: The Mental Health Implications of the Social Control of Poverty Programs," *Psychiatric Research Reports* 21 (1967), 57.

[291] Interview with Josephine Disparti, New York, New York, June 19, 2016.

Still, “community action” remained a fuzzy concept. While Disparti put together an association of community representatives, the nature of the relationship between the Health Association and the community health center had yet to be decided. Meanwhile, the set-up of the center moved quickly. Within six months it was operating a community health center that saw over one hundred patients a day.[292]

The center in Mississippi, however, proved more difficult. Hoping to avoid opposition from Southern politicians for as long as possible, Geiger and Gibson had intentionally left the location of the Southern site vague in their proposal. They both hoped to establish it in Mississippi, where they had witnessed the need for such a program firsthand. Geiger and Gibson partnered with John Hatch, an African-American activist from the South who was working as the assistant director of the Boston Housing Authority’s Division of Tenant and Community Relations.[293] Hatch immediately adopted the role of community organizer, and in late 1965, he traveled to Mississippi to scout potential locations for the health center. According to Geiger, Hatch disappeared for weeks. When he finally emerged and contacted Geiger and Gibson, they learned that “he’d been picking cotton around the state—the best way to find out what was really going on.”[294]

Hatch recommended the town of Mound Bayou, located in Bolivar County, one of the poorest counties in the country. In addition to the clear need for a health center, Mound Bayou offered a few strategic advantages. A historically all-black town, Mound Bayou had a black power structure that seemed receptive to the idea, and Tufts would be able to buy the land for the

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[292] H. Jack Geiger, “Of the Poor, By the Poor, or For the Poor: The Mental Health Implications of the Social Control of Poverty Programs,” *Psychiatric Research Reports* 21 (1967), 60.
[293] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*. New York: Bloomsbury Press, 2009), 231.
[294] Bonnie Lefkowitz, *Community Health* Centers, 37.

center directly from local residents.[295] Furthermore, Geiger hoped that placing the center in Mound Bayou would generate less political opposition from the local white AMA than placing it in an integrated town, where a federal health care program would be more likely to upset the local power dynamic.[296] Despite these advantages, Shriver delayed approval. Though he had pushed to fund programs as quickly as possible, the political implications of a community health center in Mississippi gave him pause. It was not until early 1967, when Geiger and William Maloney, the dean of Tufts Medical School, staged a sit-in in his office, that Shriver finally approved the Mound Bayou location.[297]

The delay in OEO approval, however, allowed Hatch to begin the slow work of organizing to drum up community participation for the health center. He was joined by Disparti, who, after a few months in Boston, was anxious to return to Mississippi. Hatch and Disparti canvassed the area, hoping to create a base of community support for the new center. They then divided the county into ten regions, each of which would elect its own delegates to a central group—the North Bolivar County Health Council.[298] By the time the Delta Health Center opened in November 1967, the Health Council was officially chartered as a community development corporation.[299]

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[295] Frank A. Treddinick Jr., "Letter to Nils Y. Wessel," March 3, 1966, Folder 7, Box 20, Tufts Comprehensive Community Health Action Program Records, Tufts School of Medicine Records, 1882-1994.

[296] According to Lefkowitz, even after deciding on Mound Bayou as the location, Geiger "pursued a diversionary strategy, letting it leak that Tufts had settled on an integrated town where the white physicians, the state medical society, and the health commissioner were strongly opposed to a federal program. Then he and Gibson met with the AMA and appeared to 'settle' for Mound Bayou—their first choice all along." Bonnie Lefkowitz, *Community Health Centers*, 37.

[297] Geiger later noted that this was "the only time in the 1960s…that it was a dean and not the students sitting in." H. Jack Geiger, "Contesting Racism," 111.

[298] John Dittmer, *The Good Doctors*, 234.

[299] H. Jack Geiger, "Community-Oriented Primary Care: A Path to Community Development," *American Journal of Public Health* 92, no. 11 (2002): 1714.

Meanwhile, the community health center model was beginning to gain traction. By the time the Tufts-Delta Health Center opened its doors in Mound Bayou, seven other community health centers were in operation. The centers were scattered across the country. In addition to the one at Columbia Point, there was one in Denver, two in Chicago, two in New York City, and one in the Watts neighborhood of Los Angeles.[300] Most histories of the War on Poverty assume that the idea of community action spread outward from the OEO, inspiring the creation of new community groups that then turned to the OEO for funding. An analysis of the early days of the OEO health programs, however, reveals a different dynamic. The sudden availability of OEO funding and the rush to fund workable, community-based proposals encouraged reform-minded individuals to come forward to propose programs. In most cases, these programs had preceded the OEO. Their organizers immediately seized on the opportunity to have these proposals funded, and the first wave of community health centers was born.

This dynamic was at work in Chicago. There, a community health center emerged from a complicated back-and-forth between the OEO and local health care institutions. In 1965, shortly after the OEO began accepting proposals, the Chicago health department had requested a grant for OEO funds to support a health program in Chicago. However, OEO officials, upon reviewing the grant, found it insufficient and instead gave a planning grant to the health department to commission a study on the health needs of the city's poor.[301] Upon the advice of the Welfare Council of Metropolitan Chicago, a social services organization that had been pushing the city to get outside experts to study health needs, the OEO recommended that the city hire Dr. Joyce Lashof and Dr. Mark Lepper, two physicians associated with the University of

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[300] "The Neighborhood Health Center," (Washington, D.C.: Office of Economic Opportunity, 1967), http://hdl.handle.net/2027/pur1.32754081231593.

[301] Interview with Dr. Joyce Lashof, Alameda, California, July 11, 2016.

Illinois and Presbyterian-St. Luke's Hospital, to study the health of the poor and suggest possible solutions.[302]

Lashof was already well aware of many of the problems that hospitals faced in their efforts to extend health care to poor populations. Under the guidance of Dr. Lepper at the University of Illinois' Department of Preventative Medicine, Lashof had studied the outpatient department at Presbyterian-St. Luke's. She concluded that, while the quality of acute care offered was high, a poor recordkeeping system and a lack of preventative care made continuity of care almost nonexistent.[303] In writing a report for the city's health department, Lashof saw an opportunity to propose a plan that would address these gaps in the health care delivery system. The resulting document, dubbed the Lepper-Lashof report, revealed that so-called "poverty areas" suffered from higher rates of infant mortality, premature births, and disease.[304] To address these problems, Lashof called for "a series of comprehensive family care centers and coordinated programs of care." Furthermore, she recommended that such projects be undertaken by "existing voluntary hospitals and medical schools." [305] Only such institutions, she argued, could create programs that would have both the "permanence and flexibility" needed to provide health care to the poor.[306]

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[302] Joyce Lashof, "The Health Care Team in the Mile Square Area, Chicago," *Bulletin of the New York Academy of Medicine* 44, no.11(1968), 1363.

[303] Interview with Dr. Joyce Lashof, Alameda, California, July 11, 2016.

[304] Jean Ruffin, "Mile Square Health Center in Chicago, Illinois" in *Health Services Integration: Lessons for the 1980s, Volume III* (Washington, D.C.: Institute of Medicine, National Academy of Science, 1982), 100.

[305] Jean Ruffin, "Mile Square Health Center in Chicago, Illinois" in *Health Services Integration: Lessons for the 1980s, Volume III* (Washington, D.C.: Institute of Medicine, National Academy of Science, 1982), 100.

[306] Mark H. Lepper, Joyce C. Lashof, Albert Pisani, and Iris Shannon, "An Approach to Reconciling the Poor and the System," *Inquiry* (1968), 37.

The OEO accepted the conclusions of the Lashof-Lepper report, and, in July 1966, funded one center as a demonstration—a community health center at Presbyterian-St. Luke's. The center was to serve a square-mile area containing 25,000 residents (8,600 of whom lived in a high-rise housing project) on Chicago's West Side. Lashof, who had become head of the Department of Community Medicine at the hospital after Lepper was promoted, was chosen as the center's project director.[307] In February 9, 1967, the Mile Square Health Center—a product of the partnership of the OEO and a teaching hospital—opened its doors.

It is certainly not a surprise that Lashof turned to hospitals to solve the health problems of Chicago's poor; after all, she had spent her career as a physician working in teaching hospitals. But the incident is still a revealing one. The OEO had rejected a proposal from a city health department and sought out the advice of physicians associated with teaching hospitals. Its decision in Chicago revealed a tendency to privilege the expertise of hospital-based academic physicians over that of public health officials.[308]

The health center in Watts, Los Angeles, followed a similar path. In late 1965, a few months after the Watts riots had shaken Los Angeles, the University of Southern California (USC) submitted an application to the OEO to establish a community health center in the center of Watts. Historians have tended to assume a cause-and-effect relationship between the riots and the health center. In his book on the Watts uprising, *The Fire This Time,* historian Gerald Horne suggests that, in the wake of the uprising, the health center was a political move to quell the

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[307] Jean Ruffin, "Mile Square Health Center in Chicago, Illinois" in *Health Services Integration: Lessons for the 1980s, Volume III* (Washington, D.C.: Institute of Medicine, National Academy of Science, 1982), 100.

[308] Lisbeth B. Schorr, *Within Our Reach*, 131.

unrest.[309] Horne's reasoning is understandable—many at the time, in fact, made similar reached similar conclusions. For instance, public health expert Milton Roemer, who served as the public health consultant on the commission that investigated the causes of the riots, wrote that the center was developed as a response to his recommendations.[310] This version of the story, however, is only half-complete. The OEO had already identified the Watts neighborhood as a poverty area and had solicited a proposal from USC months before the Watts riots. Though the riots certainly "fast tracked" the proposal, much of the work was already underway when the riots broke out.[311] Thus, when the South Central Multipurpose Health Services Center (SCMHSC) opened in late 1967, it was more of an example of a growing alliance between the OEO and medical schools than, as many assumed, the federal government responding to the recommendations of public health officials.

The stories behind the funding of the Mile Square Health Center and the Watts Center were not unique. Unlike the OEO's community action programs, the early OEO grants for health centers (which were first housed under the anomalous "research and demonstration" division) did not go to community groups. Instead, the majority of these grants were awarded to "individual health reformers within established institutions," usually hospitals or medical schools.[312] Out of the initial eight centers, only one—the center in Denver—was sponsored by a

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[309] According to Horne, USC president Norman Topping approved the center upon "recognizing that he was heading an institution surrounded by insurrectionists." Gerald Horne, *Fire This Time: The Watts Uprising and the 1960s* (Charlottesville: The University of Virginia Press, 1995), 351.

[310] Milton I. Roemer, "Resistance to Innovation: The Case of the Community Health Center," *American Journal of Public Health*, 78, no. 9 (1988): 1234.

[311] Jenna M. Loyd, *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014), 69.

[312] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1968* (Pittsburgh: The University of Pittsburgh Press, 1988), 65.

public health department.[313] Denver's unique arrangement soon proved to be the exception to the rule. Between 1965 and 1966, 87% of grants for community health centers were channeled through hospitals or medical schools, with only 13% going to health departments.[314]

According to Lisbeth Bamberger, the director of the OEO's Health Division, the needs of the medical schools and the needs of the federal government "happily converge[d]."[315] For health reformers, OEO grants made it possible to address what they considered long-standing problems in the health care delivery system. Medical schools and hospitals also found that they accrued a number of advantages from this arrangement. Most notably, OEO grants promised new overhead funding flowing through hospital departments. There were other benefits as well. Since Dr. Deuschle's innovative community medicine program at the University of Kentucky, medical schools had experimented with community outreach program in order to provide medical students with training outside the hospital environment. The OEO gave them the funding necessary to expand such efforts into full-fledged programs that could then become a key part of the medical curriculum. Finally, medical schools and hospitals provided the OEO with ideas, facilities, and expertise that community groups lacked. Building community groups from the ground up would have required time that, given Shriver's insistence that the OEO move to fund proposals as quickly as possible, seemed impractical. Partnering with medical schools and similar institutions was much more convenient.

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[313] David L. Cowen, "Denver's Neighborhood Health Program," *Public Health Reports* 84, no. 12 (1969): 1027.

[314] Of the 87%, 50% went to hospitals and 37% went to medical schools. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 16.

[315] Lisbeth Bamberger, "Health Care and Poverty: What are the Dimensions of the Problems from the Community's Point of View?" *Bulletin of the New York Academy of Medicine* 42, no. 12(1966): 1141.

The Community Health Care Model

Community health soon gained a wider audience. In August 1966, Senator Ted Kennedy made a visit to the Columbia Point Health Center and became convinced of the importance of the new program.[316] Soon after his visit, Kennedy, who sat on the Senate Labor and Public Welfare Committee, sponsored a successful effort to amend the Economic Opportunity Act in order to authorize a "Comprehensive Health Services Program" within the OEO and appropriate $50 million for the new program. The community health care model, previously an experiment under the research and demonstrations unit, was now an official program. Within a year, thirty-three new community health centers received funding.[317]

With its new official status came an expanded administrative apparatus. To coordinate the health center program, the OEO established the Office of Health Affairs (OHA)—a new division that would report to the OEO director.[318] Under the direction of Dr. Joseph English, the division assumed control of all health-related activities within the OEO. The growing community health center program constituted the bulk of the OHA's responsibilities.[319] To manage these programs, the division hired program analysts, who functioned as the gatekeepers of the system, evaluating and modifying proposals as they came in, in order to bring them into line with developing ideas about community health. Once the centers had been approved, the program analysts acted as liaisons between the new funded centers and the OEO. Traveling between the centers and the OEO headquarters in Washington, D.C., they monitored the centers

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[316] Lefkowitz credits this visit with instilling in Kennedy a "lifelong commitment to the [community health centers'] way of delivering services." Bonnie Lefkowitz, *Community Health Centers*, 34.
[317] Bonnie Lefkowitz, *Community Health Centers*, 10.
[318] Richard Hessler and Carolyn Beavert, "Citizen Participation in Neighborhood Health Centers for the Poor: The Politics of Reform Organizational Change, 1965-77," *Human Organization* 41, no. 3 (1982): 247.
[319] Bonnie Lefkowitz, *Community Health Centers*, 10.

to ensure they remained in compliance with OEO guidelines. By 1968, there were twenty program analysts in the OHA, managing a rapidly expanding community health center program.[320]

According to program analyst Ann Haendel, the "genius of the OEO" was in attracting a diverse group that defied the stereotypes of career bureaucrats.[321] Many program analysts, for example, were young women, often with only a few years of work experience. Building on the relationships Shriver had established, the OHA hired most of its staffers from the ranks of the Peace Corps and the AFL-CIO. Dr. English, for example, was the former psychiatric chief of the Peace Corps. Others, like Lisbeth Bamberger and the program analyst Dorothy Mann, moved to the OHA from the AFL-CIO's Industrial Union Department .[322] The division soon filled with what Mann later referred to as "activists and change agents—people who knew how to go beyond traditional roles to get things done."[323]

The OHA also benefitted from a relative abundance of reform-minded physicians interested in public health. In the 1960s, many physicians had entered the United States Public Health Service (PHS), taking advantage of a 1950 law that allowed doctors to serve a two-year stint in the PHS as an alternative to the "doctor draft."[324] The PHS had placed some of these doctors in the Peace Corps, where they had been charged with providing health care to the volunteers.[325] For many, their experience in the PHS and the Peace Corps sparked an interest in public health that continued throughout their careers. Upon returning to the United States, a

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[320] Interview with Dr. Stephen Joseph, Skype, May 17, 2016.
[321] Interview with Ann Haendel, St. Pete Beach, Florida, June 25, 2016.
[322] Interview with Dorothy Mann, Seattle, Washington, June 28, 2016.
[323] Dorothy Holland Mann, *Guide My Feet* (Kirkland, WA: LegacyONE Authors, 2012).
[324] Laurence Monnais and David Wright, *Doctors beyond Borders: The Transnational Migration of Physicians in the Twentieth Century* (Toronto: University of Toronto, 2016), 168-69.
[325] Eli Newberger, "Medicine of the Tuba," *Doctors Afield* eds. Mary G. McCrea Curnen, Howard Margaret Spiro, and Deborah St. James (New Haven: Yale University Press, 1999), 68.

number of these physicians sought positions in federal government, where the Great Society and the War on Poverty had created new opportunities for health professionals interested in government work. The OHA, with its connections to the Peace Corps, was perfectly poised to absorb these individuals, and an informal "Peace Corps to OHA" pipeline soon developed, funneling a new breed of health care professional into the ranks of the OHA.[326]

The individual reformers in medical schools and the staffers of the OEO/OHA initiated a new stage of the health center movement. Together, they formed what the political scientist Alice Sardell termed a "professional-bureaucratic complex" that pushed the vision of the community health model forward.[327] A community health center model began to coalesce, combining medical reformers' eagerness to reconceptualize health care with the OHA's mandate to address poverty through community action. Though the particulars of these centers differed, a few major elements soon emerged as the defining hallmarks of the community health center model—dedication to comprehensive health care, an emphasis on community training and employment, and a commitment to community control.

The most fundamental of these features was the commitment to comprehensive health care. By itself, this theme was not especially innovative. Comprehensive health care, after all, had been a central tenet of medical reformers' philosophies for at least a decade by the mid-1960s. From Sidney Kark in South Africa to Kurt Deuschle in Kentucky, reformers had argued that medical care needed to address the environmental causes of disease. The community health center program, however, emboldened reformers like Geiger to push these ideas of comprehensive health care even further, testing the boundaries of traditional medical care.

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[326] Phone Interview with Dr. Stephen Joseph, April 11, 2017.
[327] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986* (Pittsburgh: University of Pittsburgh Press, 1989), 13.

In a 1968 speech, Geiger argued that medical care for the poor that did not address the roots of disease as well as the symptoms was useless: "It is absolutely clear that the biological, social, economic, and political environment of the ghetto is incompatible with health/life, and no amount of health service as such will alter it. There is just no point in treating rat bites—and ignoring rats."[328] Geiger's reference to rat bites was more than just a rhetorical analogy. Many poor communities—especially urban ones—struggled with rat problems. At one center, doctors found themselves treating so many rat bites that they asked the city's public health department to investigate. Finding that the local public housing project was infested with rats, the center partnered with the health department to lead extermination efforts.[329] Similarly, at Columbia Point, administration worked with the local community to establish a "Rats and Roaches Committee" that would coordinate extermination efforts in the Columbia Point housing project.[330] Rats were only one of the environmental health issues that these centers faced. After treating multiple cases of lead poisoning, one center in the Midwest coordinated an investigation that revealed that 90 percent of local housing contained lead-based paint. The center launched a two-pronged program, meeting with local landlords to convince them to repaint their buildings and holding workshops for residents to explain the dangers of lead-based paint.[331]

In rural areas, environmental problems could be even more pressing. Finding that many nearby residents lacked access to clean water and sanitary facilities, the Delta Health Center in

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[328] H. Jack Geiger, "Health and Social Change: The Urban Crisis," *Vital Speeches of the Day*, 34 no. 15 (1968): 466.

[329] Elizabeth J. Anderson, *The Neighborhood Health Center: Its Growth and Problems* (Washington, D.C.: The National Association of Neighborhood Health Centers, Inc., 1976), 39.

[330] William Oshima, "Community Health Association Log," October 24, 1967, Folder 10, Box 13, Tufts Comprehensive Community Health Action Program Records, Tufts School of Medicine Records, 1882-1994.

[331] Elizabeth J. Anderson, *The Neighborhood Health Center: Its Growth and Problems* (Washington, D.C.: The National Association of Neighborhood Health Centers, Inc., 1976), 39.

Mound Bayou established an Office of Environmental Improvement, "charged with helping the poverty stricken population improve their surroundings and thereby promoting good health in this region."[332] The office quickly became one of the largest divisions of the center, consisting of "a director, a supervising sanitarian, two staff sanitarians, two sanitarian trainers, a home economist, […] an environmental health secretary technician, [and] three sanitarian assistants experienced in plumbing, carpentry, and heavy equipment."[333] This crew of environmental health professionals addressed a host of problems. As the nurse Cynthia Kelly explained,

> If a nurse in the field finds a home without a water supply […] out go the sanitarians and engineers with the well digger invented right here at the center and they dig a well in half a day. If there are rats coming through the floor, we exterminate them. A leaking roof? A privy falling down? Out go workers from the center—and these are local people—to patch the roof, build a new privy or take healthy adults tools from the tool bank we've scrounged together so they can make their own repairs.[334]

The Delta Health Center pushed the boundaries of health care even further. To deal with the high rates of malnutrition in the region, Geiger and Gibson encouraged the physicians to write prescriptions for food, which the center's pharmacy would then fill. When the OEO questioned this use of funds, arguing that food was not "medicine," Geiger replied, "The last time we looked in the book for specific therapy for malnutrition, it was food."[335] But "food prescriptions" were only a short-term fix; the center's administration realized a more long-term solution would be necessary. Meeting with local community members, Hatch suggested a

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[332] Andrew James, "Tufts-Delta Administers Environmental Treatment," *Journal of Environmental Health* 31, no. 5 (1969): 438, Folder 146, Box 20, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[333] Andrew James, "Tufts-Delta Administers Environmental Treatment," *Journal of Environmental Health* 31, no. 5 (1969): 438, Folder 146, Box 20, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[334] Cynthia Kelly, "Health Care in the Mississippi Delta," *The American Journal of Nursing* 69, no. 4 (1969): 762.

[335] Thomas J. Ward Jr., *Out in the Rural: A Mississippi Health Center and its War on Poverty* (New York: Oxford University Press, 2017), 74.

community garden—“a plot of maybe a couple of acres where people could come and grow stuff.”[336] The idea met with an “overwhelming community response.” Hatch had initially envisioned a garden run by forty to fifty families, but nine hundred local families applied for membership.[337] Soon, the “garden” had become a fully-fledged cooperative farm, owned and operated by local community members who worked on the farm, shared the harvest, and sold the surplus. By October 1968, six months after its members started work, the cooperative had produced a million pounds of vegetables.[338]

The Delta Center’s cooperative farm was in many ways exceptional, but health centers around the country were striving for solutions beyond traditional health care. Community health centers allowed medical reformers like Geiger to experiment with solutions that, under other circumstances, may have been considered radical or irrelevant to medical care. In doing so, these reformers borrowed elements from clinical medicine and from public health, combining them to create a comprehensive health care approach that was a major feature of the community health center model.[339]

The second distinguishing feature of the community health center model was its focus on community training and employment. Like comprehensive health care, the idea of community employment was not entirely new. Earlier models of community health, for instance, had hired and trained workers from their surrounding communities. In South Africa, Dr. Sidney Kark had

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[336] Thomas J. Ward Jr., *Out in the Rural: A Mississippi Health Center and its War on Poverty* (New York: Oxford University Press, 2017), 113.

[337] John Hatch, “Historical Sketch and Progress Reports on the North Bolivar County Farm Cooperative,” January 8, 1969, pg. 2, Folder 298, Box 40, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[338] Richard Hall, “A Stir of Hope in Mound Bayou,” Folder 298, Box 40, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[339] “The Neighborhood Health Center: Model and Federal Policy,” *Health/PAC Bulletin* 12, no. 2 (1980): 10.

relied upon “community health workers” to act as the liaison between the health center and the surrounding community. Similarly, on the Navajo Indian Reservation in the 1950s, Dr. Walsh McDermott had employed subprofessional “health visitors” to assist field nurses in community outreach. For the most part, however, these community training programs had one goal in mind—allowing the health centers to function smoothly. McDermott, for example, had hired from the community because he believed such workers would form vital links between the medical professionals and local residents.[340] Though he recognized the myriad benefits of community training, his primary goal was always to improve the quality of the health care at the center. Under the OHA, however, community training and employment assumed a new form.

Community employment fit neatly with the OEO’s larger antipoverty philosophy.[341] As the OHA was working to fund community health proposals, the OEO was simultaneously engaged in the New Careers program, a “strategy for improving the economic self-sufficiency of poor communities [by] using the skills and capacities of the very people in these communities to deliver social, educational, and health services.”[342] Popularized by education expert Arthur Pearl and self-help advocate Frank Riessman in their pamphlet, *New Careers for the Poor*, the New Careers movement held that the federal government should train the poor and unemployed as

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[340] Walsh McDermott, Kurt W. Deuschle, John Adair, Hugh Fulmer, and Bernice Loughlin, “Introducing Modern Medicine in a Navajo Community, Reprinted from Science,”131, no. 3395 & 3396, (1960): 14, Folder 3, Box 10. Walsh McDermott Papers, Medical Center Archives of New-York Presbyterian/Weill Cornell.
[341] Though scholars had long assumed that the War on Poverty lacked a jobs program, recent scholarship has argued that employment programs, were in fact, interwoven into War on Poverty programs. Gretchen Aguiar, “Head Start: A History of Implementation” (Ph.D. dissertation, University of Pennsylvania, 2012), 8.
[342] Janice M. Nittoli and Robert P. Giloth, “New Careers Revisited: Paraprofessional Job Creation for Low-Income Communities,” *Social Policy* 27, no. 2 (1998): 44.

"paraprofessionals" in human services sectors of the economy.[343] Such efforts, proponents argued, would prepare people to compete in the modern economy and, in doing so, extend American prosperity to all. Committed to the belief that efforts to fight poverty should focus on training and employment, not "handouts" or "welfare," the OEO quickly became a devotee of the New Careers strategy, and the program soon infused all OEO projects, including the health centers under the OHA.[344]

For OHA officials, community health centers offered not only a way to provide health care to underserved populations, but also an opportunity to employ the disadvantaged and place them on a career ladder that could lead to advancement. In funding and evaluating community health centers, they heavily emphasized the importance of community employment and encouraged centers to develop fully-fledged training programs for the new hires.[345] The centers quickly took notice, hiring local residents to be administrative assistants, librarians, sanitarians, and technicians.[346] At the same time, many partnered with local institutions to establish training programs for their new employees. For example, in Mississippi, the Delta Health Center partnered with the nearby Mary Holmes College, a now-defunct historically black college, to

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[343] Arthur Pearl and Frank Riessman, *New Careers for the Poor* (New York: Free Press, 1965). 13; Anthony Lenzer, "New Health Careers for the Poor." *American Journal of Public Health and the Nation's Health* 60, no. 1 (1970): 45-50.

[344] Office of Economic Opportunity, "A Strategy for Nonprofessional Career Development in Community Action Agencies," *Career Concepts in Health* 4, no. 1 (1970), Folder 114, Box 15, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[345] OHA officials subscribed to the "Jobs first—training built-in" approach delineated by Frank Riessman: under this model, centers hired applicants with little experience and then enrolled them in training programs to supplement any on-the-job education. Frank Riessman, *Issues in Training the New Nonprofessional*, (Transcript of speech, New York University, March 1967), 2, Folder 115, Box 15, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[346] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 158.

establish the "Delta Extension Program" to prepare community members for "health related careers." The program offered a variety of part-time courses for Delta Health Center employees. Those who had dropped out of high school could enroll in remedial classes, while those who had completed their GEDs were eligible to receive college credits.[347]

But the implications of community employment reached beyond a handful of training programs. Many program directors realized that a genuine commitment to community employment and training would require a wholesale restructuring of health care delivery. Health care institutions had long been dominated by professionals.[348] If community people were to be integrated into the operations of the centers, the very nature of health care—and the professional's role in it—would have to be rethought. As John Hatch and public health expert Eugenia Eng later wrote, the idea of community employment "helped to reorient health care institutions to include staff persons who had not gotten their credentials in the usual way."[349]

One of the first community health centers, the Montefiore Hospital Neighborhood Medical Care Demonstration (later the Martin Luther King Health Center), took the lead in combining opportunities for community employment with innovations in the health care delivery system. Funded by the OEO in 1966 and run by the Division of Social Medicine of Montefiore Hospital, the center covered the 45,000 residents of a 55-square-block area in the Southeast Bronx in New York City. Under the guidance of program director Harold Wise, the center

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[347] "Mary Holmes College Delta Extension Program," Folder 117, Box 16, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[348] The dominance of professionals in health institutions had been growing since the Progressive Era, when an "increased emphasis on the roles of scientific knowledge and professional training" helped professionals wrest control away from elite authorities. See Mark Schlesinger, "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy," *Journal of Health Politics, Policy and Law* 22, no. 4 (1997): 948.

[349] John W. Hatch and Eugenia Eng, "Community Participation and Control, or Control of Community Participation," in *Reforming Medicine: Lessons of the Last Quarter Century*, ed. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 236.

adopted a “health team” model, in which each patient would be assigned to a team of health care workers. Intended to ensure continuity of care, this approach allowed health care workers to coordinate their efforts and help patients avoid a “bureaucratic maze of hospital, health, and welfare services, located in different buildings and in different parts of town.”[350] “Health teams” included not just a family physician and a public health nurse, but a “family health worker.” Hired from the local community, most family health workers were married women with very little, if any, experience in health care.[351] They covered a variety of different areas, “incorporat[ing] some of the functions of the public health nurse, the social worker, the physician, and the health educator.”[352] Using the health center as their base, these workers primarily labored in the community, making home visits to patients. In addition to performing basic patient care tasks, they also performed a “variety of health education, patient care, and social advocacy activities,” such as informing patients of potential health hazards in their homes and visiting new mothers to teach them how to care for their newborns.[353] Family health care workers soon became an integral part of the health care model. Just a year after the center at Montefiore opened, the center had hired 22 family health care workers, 14 of whom had completed their six-month training programs.

These workers became the jacks-of-all-trades in the community health center movement. The “health team” model pioneered at Montefiore quickly became dominant, combining medical reformers’ interests in improving health care delivery with the OHA’s goal of community

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[350] Harold B. Wise, E. Fuller Torrey, Adrienne McDade, Gloria Perry, and Harriet Bograd, “The Family Health Worker,” *American Journal of Public Health and the Nations Health* 58, no. 10 (1968): 1829.
[351] Harold B. Wise, “The Family Health Worker,” 1830.
[352] Harold B. Wise, “The Family Health Worker,” 1829.
[353] Harold B. Wise, “The Family Health Worker,” 1830.

employment. Within a few years, the subprofessional "family health worker" was regarded as a key component of the community health center.[354]

Comprehensive health care and community employment were thus two major factors that defined the shape of the emerging community health program, but what really distinguished the community health center from previous incarnations of community health was its third distinguishing feature—its unprecedented focus on community control. In implementing its anti-poverty programs, the OEO had faced a major decision: What did "maximum feasible participation" actually mean? As Lillian Rubin later wrote, "Did participation mean that poor people would work in the programs, or that they would share the policy-making role?"[355] Though the topic engendered debate, the OEO, for the most part, sided with the more expansive understanding of the term. "Maximum feasible participation," it argued, demanded not just community employment, but also "community control"—a community role in the planning and oversight of the health centers.

Even in the early rush to fund proposals for health centers, there was a growing recognition among the OEO administrators that their partnership with medical schools and teaching hospitals might be in tension with their professed values of "community action" and "maximum feasible participation." Allowing for elements of "community control," then, could act as a "counterbalance" by giving communities the means to monitor health center

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[354] Family health care workers were a major topic of discussion and study in the early years of community health centers. For example, a conference on community health centers in June 1967 devoted a larger portion of their discussion to the topic. Many program directors attended, including Harold Wise, who spoke at length on the Montefiore model. See T. Keenan, "Notes on CF-Carnegie Meeting on Neighborhood Community Health Centers," June 8-9, 1967, Folder 784, Box 85, Subseries 1, Commonwealth Fund Records, The Rockefeller Archive Center.

[355] Lillian B. Rubin, "Maximum Feasible Participation: The Origins, Implications, and Present Status," *The Annals of the American Academy of Political and Social Science* 385, no. 1 (1969): 22.

operations.[356] Some OHA officials went even further. Like the advocates of "community empowerment" of the early 1960s, they argued that poverty was as much a social condition as it was an economic one. By giving community members a "meaningful role […] in planning and evaluating health services," health centers might instill such intangible values as "self-respect, independence, and hope."[357]

Despite these lofty goals, channels for community control were at first informal and often ambiguous. The 1966 authorizing legislation for the OEO Comprehensive Health Services Program simply stated that services should be designed "in a manner most responsive to their (neighborhood residents) needs and with their participation."[358] This vague language left interpretation largely in the hands of the individual health centers. Though many quickly established health associations to represent the community and channel its voice, there was no clear consensus of the role these associations and boards should play. At Columbia Point, for example, Tufts quickly organized a health association composed of 28 board members elected by the local community but delegated very little tangible authority to the group.[359]

In 1967, responding to the growing confusion over community control, the OEO made an effort to translate the concept into clearer guidelines. In the 1967 Program Guidelines, the agency wrote that community control "might be achieved through participation either on an advisory council or a governing board. At least one-half of the former or one-third of the latter

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[356] "The Neighborhood Health Center: Model and Federal Policy," *Health/PAC Bulletin* 12, no. 2 (1980): 2.

[357] Thomas E. Bryant, "Goals and Potential of the Neighborhood Health Centers." *Medical Care* 8, no. 2 (1969): 94.

[358] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *The Milbank Memorial Fund Quarterly* 50, no. 4 (1972): 394.

[359] Jerome L. Schwartz, "Early Histories of Selected Neighborhood Health Centers," *Inquiry* 7, no. 4 (1970): 5.

were to be neighborhood residents served by the project."[360] These standards quantified the minimum requirement for community control, though they did little to specify the role of an "advisory council." As we will see in the next chapter, community control—and the struggles to define what it meant—soon became one of the most distinctive aspects of the community health center model.

A New Model for Health Care?

As the health policy expert Bonnie Lefkowitz notes in her history of community health centers, "Ideas are translated into government programs in several ways—not the least of which is serendipity."[361] The OEO had stumbled its way into health care, but, a little over a year after Geiger and Gibson had approached Lisbeth Bamberger at the OEO, a cohesive model was beginning to emerge. The product of an alliance between the federal government and reformers in medical schools, the community health center program reflected the "community health" emphasis of medical reformers and the "community action" commitment of the OEO/OHA.

In 1967, the Commonwealth Fund and Carnegie Corporation hosted a conference on the community health center program. In attendance were the usual suspects, including Jack Geiger from Tufts, Joyce Lashof from Presbyterian-St. Luke's, and Harold Wise from Montefiore. OEO officials were also present, most notably Julius Richmond, a consultant to the OEO who was best known for his role in the development of Head Start. In some ways, the conference discussion reveals the extent to which the "community health model" was beginning to congeal. Participants largely agreed on fundamental elements like the importance of employment training

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[360] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *The Milbank Memorial Fund Quarterly* 50, no. 4 (1972): 394.

[361] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick: Rutgers University Press, 2007), 8.

and community participation. But this agreement seemed to belie some more fundamental questions. While the participants noted the need for community involvement, for example, few delved into the mechanisms through which this might be accomplished. Perhaps most crucially, the question of the "transferability" of the community health center model sparked a lively conversation. Most agreed that "health centers should probably not develop as a separate system of health care," but few provided specifics on how the systems could be integrated. While some, like Lashof, argued that "the model of community health center can be extended to all population groups, and is not only a stopgap measure to take care of people in poverty neighborhoods," others cautioned that health care for the poor had its own difficulties and thus required its own approach.[362]

For Geiger and other reform-minded physicians, community health centers offered a way to experiment with a new form of health care delivery. On their more optimistic days, they envisioned the community health care system as not just a solution for the poor, but as an entering wedge with which they could reform the nation's health care system. Geiger later said of the model, "Community health center proposals represented a criticism of the entire mainstream medical system, not just the organization of medical care for the poor; and an unspoken goal—however grandiose—of some proponents was structural reform of that system for *all* its consumers, rich and poor alike."[363] OEO officials similarly projected their own visions onto the model. For these administrators charged with implementing the War on Poverty, community health centers represented a way to interrupt the cycle of poverty. In a 1969

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[362] T. Keenan, "Notes on CF-Carnegie meeting on neighborhood community health centers," June 8-9, 1967, pgs. 11-12, Folder 784, Box 85, Subseries 1, Commonwealth Fund Records, The Rockefeller Archive Center.

[363] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 16.

editorial, OHA director Thomas Bryant expressed his hopes for the program: “Besides being health care facilities, the Centers are also a research and development tool in the effort to develop more responsive services and to solve problems that keep people poor and dependent.”[364]

A fundamental tension thus lay at the heart of the community health center model. Were the centers primarily solutions for the poor, meant to intervene in the cycle of poverty, or were they an experiment in health care that could be applied on a broader scale? Was it possible for them to be both? During the heady early years of the program, the vision of the community health center seemed capacious enough to hold all these expectations.

Implementation, however, came with its own set of problems. Medical reformers and OHA officials might have found it easy to agree while discussing the program at a conference, but turning word into actions raised new issues. The word “community,” for example, could obscure as much as it illuminated. While both medical reformers and federal bureaucrats romanticized the concept, neither group articulated a clear definition of the term. Drawn together by a shared attraction to “community,” these groups soon discovered that they had different visions of how to put their principles into practice. As the next chapter will show, these tensions would soon become apparent as community health centers struggled to define and implement community control.

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[364] Thomas E. Bryant, “Goals and Potential of the Neighborhood Health Centers,” *Medical Care* 8, no. 2 (1969): 93.

CHAPTER 4

“So Much for Apathy!”:

Debating the Meanings of Community Control

In 1971, the *Mound Bayou Voice,* a small black-owned newspaper, ran a letter written by a local Black Power group. The letter charged the Delta Health Center with a failure to heed the community’s voice: “Certainly we want to clinic here and we need it. We also did what we could to get it here but we demand to be treated as equals in our community. THE CENTER AND THE HOSPITAL BELONG TO US. We are not going to allow any sweet-talking, double-crossing, two-timing, undermining, hypocritical, soft-stepping, Southern Bigot or Northern Liberal to use our people as tools.”[365] While it is unclear whether the sentiments expressed in the letter were representative of local opinion, they highlighted the debates that raged around community health centers across the country, as local communities, having been promised “maximum feasible participation,” demanded a more prominent role in the operations of their local community health centers.

By the late 1960s, calls for community control had reached a fever pitch. During the Congressional debates over the Economic Opportunity Act in 1964, “community control” and “maximum feasible participation” had generated little debate among legislators. Just a few years later, the rhetoric of community control was everywhere and impossible to ignore. A host of New Left groups—including radical health activists—had adopted the term, motivated by the momentum of the civil rights movement and driven by what they perceived as the shortcomings

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[365] Howard Levy, “Counter Geiger,” *Social Policy* 2, no. 1 (1971): 57, Folder 357, Box 48, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

of the War on Poverty's Community Action Programs. In the hands of these activists, "community action" implied more than bureaucratic neighborhood "advisory councils." Community control, they argued, entailed "social, political, and economic autonomy," or, in the language of the black power movement, "self-determination."[366] Self-determination, as espoused by these activists, was not quite what most OEO bureaucrats had envisioned when they sought to incorporate community action into their poverty programs. As demands for community control intensified, these centers were forced to grapple with the underlying tensions in their vision of community action.

The hasty beginnings of the community health center program had left a number of questions unanswered. The OHA had begun the community health center enthusiastically, envisioning a program that would not only provide quality health care, but also politically empower the poor. They had partnered with medical reformers like Jack Geiger, who had shared this broad vision. In developing the first few community health centers, OHA administrators had largely been happy to follow the lead of these reformers, giving them a large degree of latitude in shaping the health center model. As more medical schools and hospitals flooded the administration with proposals, however, it became increasingly clear to OHA officials that reformers like Geiger were in short supply.

Medical schools had played a crucial role in the establishment of the community health center program, as their expertise and resources had made them seem like ideal grantees for OEO funds.[367] Just a few years later, however, key OHA officials began to express regrets over

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[366] Alondra Nelson, *Body and Soul: The Black Panther and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 58.

[367] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 16.

handing so much control of the program to university administrators. In a 1968 report, OHA officials Lisbeth Bamberger and Joseph English suggested that the control they had given universities might be fundamentally incompatible with demands for community control. The OHA had awarded grants to proposals from hospitals and medical schools, which had then provided channels of community participation. In doing so, Bamberger and English argued, the OHA "did not fully appreciate that the requirement of full participation by those being served after a proposal had been approved could never make up for the fact that the project had been originated and formulated by the professionals alone."[368] Despite their talk of community control, they had handed the reins to the providers of medical care, rather than the recipients of it. In an interview years later, Sanford Kravitz, the head of the research and demonstrations unit at OEO, echoed these sentiments, concluding, "the OHA's big mistake was to think that because much of the progressive thinking on health care and change came from the universities, then universities themselves would provide leadership and change."[369] The OHA, hoping to enact broad social change, had found itself "crashing against the rocky coast of institutional self-interest."[370]

By this time, a radical health movement was placing pressure on the community health program, accusing OHA administrators of relying on medical schools and hospitals in ways that compromised their commitment to social change. As they sought to expand the community health program beyond the initial handful of centers, OHA officials had to decide what constituted a

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[368] Lisbeth Bamberger Schorr and Joseph T. English, "Background, Context and Significant Issues in Neighborhood Health Center Programs," *The Milbank Memorial Fund Quarterly* 46, no. 3 (July 1, 1968): 292.

[369] Richard Couto, *Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South* (Philadelphia: Temple University Press, 1991), 278.

[370] Richard Couto, *Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South* (Philadelphia: Temple University Press, 1991), 278.

community health center. They had to establish a working definition of the concept they had paid so much lip service to—community control. This chapter will examine how these tensions over the meaning of community control—and how it should be implemented—tested the community health center program and the tenuous alliances upon which it relied.

"Seize the Hospital to Save the People"

By the late 1960s, calls for community control seemed to be coming from all directions. On the one hand, a newly politicized generation of medical reformers was coming of age. Having cut their teeth serving alongside the Medical Committee for Human Rights (MCHR) during Freedom Summer in Mississippi, they now searched for ways to reconcile their political leanings and their professional training. At the same time, the civil rights movement was entering a new era. As the evolving movement shifted its focus to northern urban centers, a new set of activists sought to expand the definition of civil rights, arguing that "racial oppression was more commonly advanced through social abandon."[371] For the Black Panthers, dismantling Jim Crow segregation was not sufficient. Activists also had to address issues like social welfare programs, where social neglect could be just as harmful as the more visible forms of oppression. Many of these activists turned their attention to health, alleging that neglect and mistreatment in health care was a major source of racial inequality. These groups soon developed what the sociologist Alondra Nelson calls a "social health" perspective that combined the expansive definition of health advanced in the 1948 charter of the World Health Organization with the

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[371] Alondra Nelson, *Body and Soul: The Black Panther and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 5.

theory of “Third World” revolutionaries such as Mao Zedong, Ernesto “Che” Guevara, and Frantz Fanon.[372]

At the same time, the MCHR was moving leftward. In the early and mid-1960s, the MCHR had been known for providing a “medical presence” at civil rights marches but had generally avoided direct political involvement, preferring to retain some sense of neutral professionalism. By the latter half of the decade, the MCHR was increasingly pulled by a younger generation of activists who hoped the MCHR could provide a counterbalance to the conservative AMA.[373] In 1967, the MCHR adopted a resolution denouncing the war in Vietnam, signaling its closer alliance with emerging leftist groups.[374]

Black Panthers, Young Lords, counterculturists, the New Left, and feminists confronted injustice in health care by demanding that health care institutions be responsive to the communities they served. At the same time, many of these groups, attempting to turn theory into praxis, established their own free clinics as democratic alternatives to mainstream institutions. These clinics sought not only to provide necessary medical services to underserved communities, but also to empower patients and encourage them to participate in decisions affecting their own health care.[375] The slogan of the Berkeley Free Clinic, for example, aptly summarized its mission, “Health Care for People, Not Profit.”[376]

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[372] Alondra Nelson, *Body and* Soul, 11, 64-65

[373] Lily M. Hoffman, *The Politics of Knowledge: Activist Movements in Medicine and Planning* (Albany: State University of New York Press, 1989), 72-74.

[374] Lily M. Hoffman, *The Politics of* Knowledge, 72.

[375] For an account of the Black Panther clinics see Alondra Nelson, *Body and Soul: The Black Panther and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011). For more on feminist-run clinics, see Jennifer Nelson, *More than Medicine: A History of the Feminist Women’s Health Movement* (New York: New York University Press), 2015.

[376] Alondra Nelson, 81.

As this radical health movement gained momentum, it also placed new pressure on existing medical institutions. Tensions ran high. In the late 1960s, a number of clashes over community control erupted at hospitals and medical schools across the country, creating an unprecedented challenge to a well-entrenched system of professional authority. One of the most well-publicized of these battles erupted in New York in the summer of 1970. At Lincoln Hospital in the South Bronx, student activism converged with community unrest to create a volatile combination.

The 1960s had produced a new breed of medical student—the medical student activist.[377] The civil rights movement and, later, the antiwar movement ignited student movements in universities, and medical schools were not immune from the political turmoil.[378] In 1964, hundreds of medical students had joined MCHR doctors in the South during Freedom Summer. For these students, the political ferment in the South seemed to lay bare a stark disconnect between their studies and the reality of medical practice. Returning to their medical schools at the end of the summer, many were inspired to turn to political activism. Students found the AMA's consistently reactionary positions disheartening. Though the AMA billed itself as the voice of organized medicine, students found it "complacent" and "ignorant of the health problems that beset many

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[377] In 1969, *The Pharos of Alpha Omega Alpha—Honor Society* ran a series of articles on medical student activism: Lucas, C. Clement Jr., "Roots of Student Activism in Medical Schools." *The Pharos* 32 (1969): 112-113; S. Douglas Frasier, "The Medical Student as Activist, *The Pharos*. 32 (1969): 115-118; David T. Graham, "Reflections on the Symposium on 'Medical Student Activism," *The Pharos* 32 (1969): 107-109; Ben Rubenstein, "Roots of Student Activism in Medical Schools," *The Pharos* 32 (1969): 134-136.

[378] A great deal has been written on student protest in the 1960s. Some examples include: David Chalmers, *And The Crooked Places Made Straight: The Struggle for Social Change in the 1960s*. (Baltimore: Johns Hopkins University Press, 2012); William L. O'Neill, *Coming Apart: An Informal History of America in the 1960's* (Chicago: Ivan R. Dee Publisher, 2004).

Americans."[379] Discouraged by the state of the medical profession, students turned to medical schools, hoping to reform the profession by changing the way doctors were trained. "Undeniably," the doctor and activist Fitzhugh Mullan wrote, "the schools of medicine produced the physicians of the nation who became the AMA in all its affluence and self-satisfied conservatism."[380]

Early clashes between budding student activists and medical school administrators often revolved around seemingly minor issues. At the University of Chicago medical school, for instance, the Dean of Students' request that the student Jim Waller shave his beard sparked a campaign among students for the right to wear beards. The SWAB (Save Waller's Beard) campaign that resulted may have appeared superficial, but it became a symbolic battleground for broader issues of authority and discipline in medical school—"the individual and the rights of the individual against the encroachments of the institution."[381] Soon, however, students began to turn their attention to larger issues, pushing their schools to take on more responsibility for the health of their surrounding communities, especially the poor and disadvantaged. As on undergraduate campuses, students in medical schools rejected notions of "ivory towers." [382] Rebelling against a system they found tedious, anti-intellectual, and largely "nonclinical," they demanded that their institutions engage with the communities outside their walls.[383]

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[379] Fitzhugh Mullan, *White Coat Clenched Fist: The Political Education of an American Physician* (Ann Arbor: University of Michigan Press, 2006), 50.

[380] Mullan writes that there was in fact a "wide chasm" between the AMA, which represented the practitioners of medicine, and the teachers of medicine who populate the faculty of medical schools. Fitzhugh Mullan, *White Coat, Clenched Fist,* 50.

[381] Fitzhugh Mullan, *White Coat, Clenched Fist*, 21.

[382] "Unrest on the Medical Campus," *Medical World News*, October 13, 1967, 64.

[383] In *White Coat Clenched Fist,* Mullan argues that much of medical school was a socialization process, not a genuine education. On his first year at medical school, Mullan writes, "The competitiveness, callousness, and the mindless discipline that the first year of medical school taught and that anatomy epitomized were destructive to me personally and to medical students in general." Fitzhugh Mullan, *White Coat Clenched Fist*, 10.

As this new generation of medical students became politicized, it also began to organize. In 1965, Bill Bronston, a medical student at USC, founded the Student Medical Conference (SMC), an organization of medical, nursing, and dental students in Los Angeles. Soon, similar organizations were cropping up across the country, connecting like-minded students, organizing conferences, and publishing their own newspapers. In the fall of 1965, many of these organizations merged to create a loose coalition known as the Student Health Organizations (SHO).[384]

From 1965 to 1968, the SHO organized a series of Summer Health Projects (SHPs) that placed hundreds of medical students from dozens of schools into impoverished urban and rural communities. In New York, Chicago, Los Angeles, San Francisco, and California's Central Valley, these students worked alongside community organizations to improve health care for poor populations.[385] Many of these students acted as "patient advocates" in clinics and became involved in political organizing, helping grassroots organizations develop "health committees" that could advocate for community interests at nearby hospitals.[386]

The SHO and Student Health Projects had been born in a "spirit of temperate protest," products of a liberal faith in federal government intervention. By 1968, however, medical students—like other student activists—were growing disenchanted with the possibilities of liberal progress. Increasingly, they began to regard themselves as part of the "system," and thus part of the problem. The Student Health Projects, they argued, had benefited the students more than the communities they served. As one student wrote, "when the project [was over] the people

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[384] Naomi Rogers, "'Caution: The AMA May Be Dangerous to Your Health': The Student Health Organizations (SHO) and American Medicine, 1965-1970," *Radical History Review* 80 (2001): 7.

[385] For more on the Summer Health Projects, see Michael R. McGarvey, Fitzhugh Mullan, and Steven S. Sharfstein, "A Study in Medical Action—The Student Health Organizations," *New England Journal of Medicine* 279 (1968): 76-77.

[386] Michael R. McGarvey, Fitzhugh Mullan, and Steven S. Sharfstein, "A Study in Medical Action—The Student Health Organizations," 76.

were left high and dry without any continuance of health care. In other words, the community was no better off when the student went back to school."[387] These concerns highlighted the questions that had dogged the SHO since its conception—namely, what was the role of the radical professional? Were medical students, by the very nature of their professional training, "paternalistic interlopers"?[388] Was it possible to reconcile professional expertise with community empowerment?

These questions had no easy answers, and by 1968 it was clear that no single vision bound together SHO members. One member, a Harvard medical student, wrote that the SHO was "like a psychedelic bus cruising to pick up the guys who'd ought to make this trip. Now each of us has to propose a place to go […] We should have given this more consideration back when we were busy rounding up passengers."[389] The 1968 California Summer Health Project was beset by internal divisions—"education vs. service, provision of health service vs. community organization, dependence on government funding, the extent of involvement in political activity such as draft resistance and opposition to the Vietnam War, and the overriding issue of racism, both white and black."[390] By 1969, the program shuttered after the USC chapter of the SHO voted to pause for "reappraisal."[391] Pulled towards competing visions, the SHO buckled shortly after. Without a centralized national structure, the organization succumbed to a "rapid diffusion of direction" and a subsequent loss of identity, finally falling apart in 1970.[392]

Despite its dissolution, the SHO left behind a legacy of medical activism. As its members earned their medical degrees, they graduated to the next stage of their careers—internship and residency. Scattering across the country, they brought their politics and their

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[387] Naomi Rogers, "'Caution: The AMA May Be Dangerous to Your Health,'" 15.
[388] Naomi Rogers, "'Caution: The AMA May Be Dangerous to Your Health,'" 15.
[389] Fitzhugh Mullan, *White Coat Clenched Fist*, 63.
[390] S. Douglas Frasier, "The Medical Student as Activist," *The Pharos* 32 (1969): 116.
[391] S. Douglas Frasier, "The Medical Student as Activist," *The Pharos* 32 (1969): 116.
[392] Fitzhugh Mullan, *White Coat Clenched Fist*, 64.

particular brand of activism with them. One of these students was Fitzhugh Mullan, a recent graduate of the University of Chicago medical school. Like many SHO alumni, Mullan elected to complete his internship at a public hospital, eventually selecting Jacobi Hospital in the Bronx.

For Mullan and his fellow SHO veterans, the conditions in inner-city hospitals came as a shock. Students who had valued community involvement soon found that these hospitals offered little opportunity to engage with patients or the community. Furthermore, working weeks of 80 to 120 hours, these interns had difficulty finding time for their political commitments. By his second year at Jacobi, Mullan began to discuss his concerns with Marty Stein, a former SHO member from Berkeley who had come to Jacobi at the same time as Mullan. The two discovered a shared sense of isolation at finding themselves to be a minority in a large hospital that functioned like a machine. Worried that they were losing their political commitments, Mullan wondered, "Weren't we becoming an indistinguishable part of the system?"[393]

As Mullan and Stein talked, they began to realize that their concerns were not unique. As former SHO members had dispersed across the country, they had been absorbed by a massive medical system. What they needed, Stein decided, was to establish "critical mass," or "a setting with enough like-minded people who object to the present way of practicing medicine so that ideas can grow and have an impact."[394] With the assistance of their fellow intern Barbara Blase, Stein and Mullan began to sketch out a plan to recruit former SHO members and other politically active interns and residents to a single department within a hospital. There, they would achieve the critical mass that would allow them to overhaul the department to align with their political vision.

They soon set their sights on Lincoln Hospital, a small, decrepit hospital in the Southeast Bronx. Like Jacobi, Lincoln was a city hospital affiliated with a medical school (Einstein Medical

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[393] Fitzhugh Mullan, *White Coat Clenched Fist*, 96.
[394] Fitzhugh Mullan, *White Coat Clenched Fist*, 96.

College). However, unlike Jacobi, Lincoln was firmly rooted in its surrounding community. Whereas Jacobi drew patients from a widely dispersed geographical area, Lincoln's patients came from the area surrounding the hospital, with many traveling to the hospital on foot. Lincoln's connections to its community appealed to Mullan and Stein. Committed to principles of "community control," they saw Lincoln's community base ripe for political organizing efforts.[395] With the involvement of the administration at Lincoln and Einstein, they settled on Lincoln's Pediatric Department, run by the well-regarded physician Dr. Arnold Einhorn. With the approval of Einhorn, who relished the prospect of an influx of talented medical graduates, Mullan and Stein assembled a team of 18 interns and 11 residents.[396] Dubbing themselves, the "Pediatric Collective," these graduates arrived at Lincoln in the summer of 1970 with an ambitious vision.

Many SHO members had grown disenchanted with the prospects of short-term interventions that benefited the student more than the patient, and the Pediatric Collective was meant as a corrective to these earlier efforts. Rather than emphasize the educational benefit of community outreach, the Collective highlighted its "shared commitment to the community" and its goals of "transferring technical knowledge to the people."[397] Furthermore, while the SHO had been rooted in a liberal understanding of progress, the Collective immersed themselves in the works of revolutionary writers and philosophers. Reading Frantz Fanon's work on doctors as agents of colonialism, for example, these activists sought to carve out a new role for the activist-professional.[398]

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[395] Fitzhugh Mullan, *White Coat Clenched Fist*, 97-98.
[396] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 219.
[397] Merlin Chowkwanyun, "On Fitzhugh Mullan's: *White Coat, Clenched Fist*," *Social Medicine* 2 (2007): 100.
[398] Merlin Chowkwanyun, "On Fitzhugh Mullan's: *White Coat, Clenched Fist*," 102.

The new program would center on service to the community, collective leadership, and, most significantly, community control.[399] Mullan later wrote of the Collective's commitment to community control, "The patient—the consumer—had been excluded too long from having a say in his own medical care and we saw it as our job to build bridges, to form alliances with community groups who could begin to participate actively in the affairs of the hospital."[400] The Collective, then, was proposing a significant revamping of the traditional department. In a system where medical authority flowed from the top down, the Collective's plan for community control represented a major departure from the status quo.

At the very moment that these activists were forming the Collective, local community groups were also beginning to make their dissatisfaction with Lincoln known. Lincoln had long held a reputation for being a "butcher shop." Its facilities were decaying, cockroach-ridden, and, in some cases, dangerous (Mullan noted the irony of treating children for lead poisoning when the hospital itself contained a dangerous amount of lead in its paint).[401] The quality of its staff was generally poor. Unable to attract qualified American physicians, Lincoln was staffed primarily by foreign medical graduates who hoped to do a short stint in the hospital before moving on.[402] Local community residents saw the hospital as a last resort, to be used only in emergencies.

By the late 1960s, community frustration with the hospital had reached a boiling point. In 1969, workers in the Lincoln Community Mental Health program staged a sit-in, demanding the removal of two administrators and reforms that would make the program more responsive to community needs.[403] The protest met some success (the administrators were replaced), but, more

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[399] Fitzhugh Mullan, *White Coat Clenched Fist*, 105.
[400] Fitzhugh Mullan, *White Coat Clenched Fist*, 105.
[401] Fitzhugh Mullan, *White Coat Clenched Fist*, 113.
[402] Fitzhugh Mullan, *White Coat Clenched Fist*, 124.
[403] Merlin Chowkwanyun, "On Fitzhugh Mullan's: *White Coat, Clenched Fist*," 99.

significantly, it galvanized local community forces. Protestors began to connect with the Black Panther party and the Young Lords, who pushed them to understand that their relationship with Lincoln not as just a local conflict, but "as part of a larger health struggle, part of the way that white, well-to-do bureaucrats dealt with black and Puerto Rican people."[404] In the hands of these activists calling for Third World leadership, "community control" began to assume broader resonances.

The Collective had hoped to work with the community to organize politically, but its members soon found themselves struggling to catch up. In June 1970, a month before the Collective arrived, a local community group called "Think Lincoln" set up a table in the hospital lobby to deal with patient complaints. Just a few weeks later, on July 14, some 150 members of the Young Lords staged a takeover of the Nurses' Residence at the hospital. Barricading themselves in, they transformed the auditorium into a clinic, administering free screening tests for anemia, tuberculosis, and lead poisoning.[405] The Collective had not been consulted on the action, but, sympathetic with the cause, they joined the protestors in a show of support. For 12 hours (before their removal by police), the activists ran an infirmary and a daycare center. A slogan, painted on a bedsheet and hung out of the hospital's sixth-floor window, summarized their aims— "Seize the Hospital to Serve the People."[406]

The most immediate effect of the hospital takeover was the dismissal of the Dr. Einhorn, who, though initially supportive of the Collective, had grown increasingly exasperated with its radical bent, and his replacement by Dr. Helen Rodriguez-Trias, a Puerto Rican physician with

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[404] Fitzhugh Mullan, *White Coat Clenched Fist*, 140-141.
[405] John Dittmer, *The Good Doctors*, 220; Fitzhugh Mullan, *White Coat Clenched Fist*, 144.
[406] Fitzhugh Mullan, *White Coat Clenched Fist*, 145.

community support.[407] Perhaps more significantly, the takeover was also a galvanizing moment for community activists interested in health care. In the aftermath of the protests, Think Lincoln and Young Lords activists coalesced to form a new group, the Health Revolutionary Unit Movement (HRUM). Joining forces with similar groups at other hospitals, the HRUM quickly expanded to a city-wide movement of black and Puerto Rican hospital workers and radical physicians. Echoing the theme of community control of health services, they published a ten-point program, stating that their primary goal was "to educate and unify all our people and to expose the corrupt health system that keeps our people weak and unable to fight for self-determination and complete liberation."[408]

Protests like the one at Lincoln, where medical activism and community activism converged, thus threw a spotlight on the burgeoning radical health movement and its expanding demands for community control. In the process, the protestors coopted the language of the War on Poverty. While government bureaucrats had used community control in a loose sense, often using it and community participation interchangeably, radical health activists advanced a much more robust definition of the term. To them, community control represented not just a way to organize health care, but an instrument of political transformation.

"Community" Control

As the radical health movement adopted the term "community control," the OHA struggled to determine what it meant in practice. The first challenge facing OHA administrators was a deceptively simple one—who was the "community"? As the American Studies scholar Alyosha

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[407] This move was not without critics. The incident quickly drew the ire of the Jewish Defense League after insinuations that the dismissal of Einhorn (who was Jewish) was an anti-Semitic move. For the members of the Collective (most of whom were Jewish), these charges came as a shock. John Dittmer, *The Good Doctors*, 222.

[408] John J. McNamara, "The Revolutionary Physician—Change Agent or Social Theorist," *New England Journal of Medicine* 287, no. 4 (1972): 171-5.

Goldstein writes in his study of the OEO's Community Action Programs, Congressional legislation had "presumed a relatively unproblematic notion of local community."[409] Legislators and policymakers had assumed that racial and ethnic groups would map easily onto a spatial landscape, allowing geographic boundaries to be drawn around distinct "communities."[410] Implementing these policies, however, proved more challenging than these policymakers had assumed.

The first health centers sidestepped these issues by adopting a broad definition of community, drawing a geographic boundary around a center and declaring that everyone living within a certain radius was a member of the "community." In some areas, the boundary was obvious. The Columbia Point center in Boston was established to serve a specific public housing project. Other centers, however, faced murkier borders and more complicated demographic calculations. The Mile Square Center in Chicago, for instance, used data from the 1960 census, the Chicago Housing Authority, and the District Office of the Cook County Department of Public Aid to identify an area of concentrated poverty.[411] Regardless, these first centers tended to be inclusive, and no additional requirements were imposed upon patients other than living in the designated area.

As the program grew, however, administrators began to raise more questions about what constituted a "poverty neighborhood." At the outset of the program, administrators had operated on the assumption that the overwhelming majority of people living in areas of "concentrated poverty" would fall below the poverty index. It quickly became evident, however, that these so-called "poverty neighborhoods" were economically diverse, with only 40-60% of the population

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[409] Alyosha Goldstein, *Poverty in Common: The Politics of Community Action During the American Century* (Durham: Duke University Press, 2012), 153.
[410] Alyosha Goldstein, *Poverty in Common*, 160.
[411] Mark H. Lepper, Joyce C. Lashof, Albert Pisani, and Iris Shannon, "An Approach to Reconciling the Poor and the System," *Inquiry* (1968): 39.

of low-income neighborhoods meeting the standard of the poverty index.[412] At the same time, the OHA faced Congressional pushback. In 1967, fearing the specter of "socialized medicine," Congress passed an amendment that limited the program's free service to "low-income" residents. As a result, the OHA, which had initially imagined the community health center as an antidote to means-tested "welfare medicine," was forced to enact complex payment structures that divided the population based on income and assigned payment plans accordingly.[413] This early narrowing of scope undercut some of the more far-reaching goals of the program. The most ambitious health reformers had hoped that the community health center program could be a demonstration program for a new approach to health care. They now had to confront a central question—was "community" just for the poor?

At the same time that OHA administrators struggled to define "community," they grappled with how to select representatives from the community. The OEO Program Guidelines had laid out some primary guidelines for community control, requiring community health centers to establish either advisory councils (with half of its members drawn from the community) or governing boards (with one-third of its members drawn from the community).[414] These guidelines, however, did not address some central questions. For example, how should community health centers select "community representatives"? Who could be said to represent the community?

Again, some centers encountered more obstacles than others. In some cases, where the OHA was able to partner with already-developed community organizations in the designated area, these organizations provided an existing structure that acted as a voice for the community.

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[412] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *The Milbank Memorial Fund Quarterly* 50, no. 4 (1972): 409-410.
[413] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," 410.
[414] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," 394.

In such situations, community health centers could work closely with the organizations to ensure the project reflected community input.[415] For most communities, however, representation was not so clear cut. The OHA often found itself playing the role of community organizer. After receiving a proposal for a center, the OHA would send a program analyst into the surrounding community to help identify "natural leaders," form relationships with them, and work with them to build community organizations that could act as effective conduits for the voice of the community.[416] The OHA also requested the help of other government agencies in their efforts. For example, OHA analysts found VISTA volunteers to be invaluable sources of information. Having worked closely with communities, VISTA volunteers understood the landscape of their communities and were able to help OHA analysts identify community leaders.[417]

The question of identifying a community's "natural leaders," though, was often a politically fraught one. OHA officials and medical reformers found themselves struggling to differentiate between "authentic" and "inauthentic" leadership. In a set of guidelines issued in 1968, the OEO had required that all health programs be "truly responsive to the needs and wishes of those it is designed to serve."[418] But health center officials soon found that communities did not speak with a single voice.

The word "community" implied a cohesive unit, but that assumption often failed to align with the reality on the ground. For example, while Columbia Point had been an easy community to define, it proved much harder to organize. Linked by little more than shared housing, most

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[415] OEO program analyst Dorothy Mann remembers working with a community organization to establish a community health center in Detroit. Interview with Dorothy Mann, Seattle, Washington, June 28, 2016.

[416] Interview with Dorothy Mann, Seattle, Washington, June 28, 2016.

[417] Interview with Dorothy Mann, Seattle, Washington, June 28, 2016.

[418] The Comprehensive Neighborhood Health Services Program: Guidelines. Health Services Offices, Community Action Program, Office of Economic Opportunity, Washington, D.C., March 1968.

residents felt very little allegiance to a "community." The Health Center thus devised a representation scheme that relied on demographics, assembling a council by choosing one representative from each targeted demographic. These target demographics could be very specific. Council bylaws, for instance, called for three "female head[s] of family with interests similar to many other women raising a family without a father," one "person of Spanish origin respected by the Spanish-speaking in the community," and one "elderly resident with income, interests and other characteristics similar to the typical elderly resident in the community," among others.[419] Often, power struggles among various community groups threatened to undermine the notion of community representation. In these cases, too, relying on demographic information to organize a council proved useful. The Mission Neighborhood Health Center in San Francisco, for example, served a diverse Hispanic population consisting of several different nationalities. In order to manage the tensions among these groups, the Center devised a structure that divided spots on its advisory council according to country of origin.[420] In these cases, then, community representation was reduced to demographic calculations.

In addition to managing conflicts within a community, OHA officials and health center administrators also had to reckon with existing local power structures. Jack Geiger, for instance, worried that the rush to fund proposals often resulted in an over-reliance on a community "elite." He argued that, in their hurry to develop a working program, universities or other professional organizations set up "instant community organizations." Searching for the "community," they found it easy to rely on the most prominent members: "These are almost always the existing elite in the community—those community people who are active in other projects already there or

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[419] "Columbia Point Community Development Council By-Laws," Folder 1, Box 15, Tufts Comprehensive Community Health Action Program Records, Tufts School of Medicine Records, 1882-1994.
[420] Interview with Dorothy Mann, Seattle, Washington, June 28, 2016.

who already hold leadership positions in some group or who have strong political or ideological motivations. They have internalized the community; they say, 'Looking for the community? Look no further; here we are!'"[421] This arrangement proved convenient for the professionals, who were seeking a "passive, window-dressing, grateful, powerless advisory committee" to rubber stamp their proposals, and the community elite, who benefited from the status quo.[422] In contrast, Geiger argued, effective grassroots organization required time and effort—going door to door and organizing small-scale meetings to build a base of community support.[423]

The OHA's conception of community "authenticity" tended to align with Geiger's. For the most part, the OHA was wary of local elites. To them, "grassroots" leadership should come from the bottom up, and they prided themselves in circumventing local elites to channel the "authentic" voice of the community. At the same time, however, others expressed concern that, in eschewing the existing local power structure, the OHA was needlessly handicapping their own efforts. In a retrospective on the community health center program, John Hatch, the organizer at the Delta Health Center, wrote that the OEO romanticization of the "grassroots" could often be counterproductive. In trying to avoid the local elite, Hatch contended, the OEO relied on "unrealistic, and at times wild, criteria" to identify leadership. "In some cases," Hatch wrote, "respected and influential members of the community, such as schoolteachers, preachers, and funeral directors, were categorically excluded from participation."[424] According to Hatch, these local figures may have "a stake in the existing order," but their "struggle for change" was funda-

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[421] Jack Geiger, "What Happened at Columbia Point," Folder 357, Box 48, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.
[422] Jack Geiger, "What Happened at Columbia Point."
[423] Jack Geiger, "What Happened at Columbia Point."
[424] John W. Hatch and Eugenia Eng, "Community Participation and Control: Or Control of Community Participation," in *Reforming Medicine: Lessons of the Last Quarter Century*, ed. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 234.

mentally the same.[425] By excluding them from their definition of an "authentic" community, the OEO was overlooking the value that such community members may have been able to offer.

Community politics were also complicated by the rise of radical politics and the black power movement, which further politicized the question of who could be said to represent the community. At the Watts center, for instance, the language of black power framed a conflict between black doctors and Black Power groups.[426] When local black doctors, who had been excluded from involvement in the Watts center, accused university personnel of being "carpetbaggers," arguing they were trying to take advantage of a poor black community, local black power groups flipped the script.[427] In an open letter, titled "Where Were You, Doctor?," an anonymous group took aim at the local black doctors, claiming they were educated "Uncle Toms" who had abandoned the community: "Most of you doctors went to schools in the South and then migrated to Los Angeles […] In all probability, you don't even know where Watts is […] You drive to your dirty, dinky office in your big white or black Cadillac […] and then you retreat to your Baldwin Hills or Leimert Park mansions."[428] Here, claims of "authenticity" were a weapon that could be wielded to exclude certain members and define qualifications for community members, ultimately drawing a circumference around a community. By highlighting racial and class divisions within a single community, the rhetoric of "authenticity" further complicated any OEO claims to identify a singular community voice.

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[425] John W. Hatch and Eugenia Eng, "Community Participation and Control: Or Control of Community Participation," in *Reforming Medicine: Lessons of the Last Quarter Century,* ed. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 234.

[426] Jenna Loyd, *Health Rights Are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: The University of Minnesota Press, 2014), 72.

[427] Jenna Loyd, "Where is Community Health?: Racism, the Clinic, and the Biopolitical State," *Rebirth of the Clinic: Places and Agents in Contemporary Health Care*, ed. Cindy Patton (Minneapolis: The University of Minnesota Press, 2010), 54.

[428] "Where Were You Doctor?" Personal Papers of Dr. Robert Tranquada.

Community "Control"

Defining the community and identifying its representatives, however, was only half the battle. Once appropriate community representation had been selected, the OHA still needed to determine what role these representatives should have in the community health center. Since the inception of the War on Poverty, the program's policymakers had used the terms "community control" and "community participation" interchangeably to denote community involvement in health center administration. As Tufts sociologists noted in a 1973 evaluation of the health center program, the OEO's "nebulous mandate of participation or control" bred confusion over the role of the community.[429] Official OHA guidelines offered little concrete help. While program guidelines stated that health centers "must be developed, conducted and administered with the full and active participation of the persons served," they did not provide further details about what constituted "active participation."[430]

At the same time, the rise of a radical health movement and events like the takeover at Lincoln Hospital made the OHA's ambiguous position increasingly untenable. If policymakers had equated control and participation, radicals and community activists pushed for a more expansive definition of "control." The activists at Lincoln, for example, defined community control as "the power to hire and fire all staff, including professionals, and, as they say, 'run' all of the departments, including clinical ones."[431] This definition soon gained currency among activists and scholars alike. Barbara Ehrenreich, a health scholar and prominent member of the

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[429] Peter Kong-Ming New, Richard M. Hessler, and Phyllis Bagwell Cater, "Consumer Control and Public Accountability," *Anthropological Quarterly* (1973): 197.

[430] The Comprehensive Neighborhood Health Services Program: Guidelines. Health Services Offices, Community Action Program, Office of Economic Opportunity, Washington, D.C., March 1968.

[431] Steven Jonas, "A Theoretical Approach to the Question of Community Control of Health Services Facilities," *American Journal of Public Health* 61, no. 5 (1971): 917.

NYC-based health activist group the Health Policy Advisory Center (Health/PAC), wrote that "the right of nonprofessionals to discipline professionals whom they judged negligent" constituted a major part of community control.[432]

The radical health movement, combined with the vagueness of OEO guidelines, thus set community control on a collision course with medical professionals. The community health center program presented special problems. Though battles for community control had been waged within community action programs across the country, community health programs, by their very nature, relied heavily on professional expertise. Professional opinions, however, could often conflict with the priorities of the community. In such cases, it was left to the OHA to determine whose concerns should be privileged. If community control meant, as Ehrenreich posited, the "right of nonprofessionals to discipline professionals," how could the notion of professional expertise be reconciled with the ideal of community control? Who, ultimately, held the "right of final decision"?[433]

The OHA had hoped to circumvent this dilemma by empowering what they called "change agents"—visionary physicians like Geiger from the professional world who were deeply committed to community control.[434] These "maverick" doctors, they believed, could help to reform the system from the inside out. However, they soon found this approach insufficient. As one OHA analyst pointed out, innovators like Geiger, who conceived of health in an expansive way, were rare.

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[432] Steven Jonas, "A Theoretical Approach to the Question of Community Control of Health Services Facilities," 917.

[433] Steven Jonas, "A Theoretical Approach to the Question of Community Control of Health Services Facilities," 917.

[434] Jenna Loyd, "Where is Community Health?: Racism, the Clinic, and the Biopolitical State," *Rebirth of the Clinic: Places and Agents in Contemporary Health Care,* ed. Cindy Patton (Minneapolis: The University of Minnesota Press, 2010), 47.

As the program grew, the OHA found new project directors to be increasingly "ordinary."[435] Furthermore, even "mavericks" were still fundamentally professionals.[436] As Jack Geiger later admitted, professionals' "technical expertise" made some imbalance of power unavoidable.[437]

The question of whether professionals could be "change agents" was not unique to the community health center program—the SHO, after all, had grappled with exactly the same question, wondering if their professional status relegated them to the role of "paternalistic interlopers."[438] Similarly, the relationship between professionals and the community had been at the heart of the conflict at Lincoln and the Pediatric Collective's efforts to upend traditional professional hierarchy. But the community health center kept these issues at the forefront of public debate. While the liberal reformers who operated many of the health centers maintained the need for professional expertise in order to provide the best care, radical health activists criticized what they saw as the professional elitism of the community health program and attacked the role of medical schools.

The debate over the role of professionals in the centers was best encapsulated by an exchange in the journal *Social Policy* between Geiger and Dr. Howard Levy, a health activist who had become well-known among radical antiwar circles for his refusal to provide medical training to Green Berets in the military.[439] In an article titled "Hidden Professional Roles,"

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[435] Interview with Ann Haendel, St. Pete Beach, Florida, June 25, 2016.

[436] Hal Strelnick, "Expanding Sutton's Law," *Health/PAC Bulletin* 12, 22.

[437] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 21.

[438] Naomi Rogers, "'Caution: The AMA May Be Dangerous to Your Health': The Student Health Organizations (SHO) and American Medicine, 1965-1970," *Radical History Review* 80 (2001): 15.

[439] Levy had refused on the basis that these "aidmen," in contrast to traditional medics, were "taught to use their medical skills politically, to offer their services, for example, to civilian populations in return for information or loyalty." John Dittmer, *The Good Doctors*, 167-68.

Geiger attacked what he saw as the radical inclination to dismiss the value of professional training. Radical health activists, he argued, "failed to distinguish between technical training (the specific acquisition of specific knowledge of skills) and the reactionary socialization that often accompanies this training."[440] By focusing on the political values attached to professionalism, Geiger argued, they overlooked the ways in which professional training made good patient care possible. Furthermore, Geiger contended, the radical critique of professionalism had pushed too far in the opposite direction. Shunning an elite of professionals, he wrote, radicals had inadvertently replaced it with "a community-worker elite."[441]

Levy countered (in an article cleverly titled "Counter Geiger") that Geiger had mischaracterized the intentions of radical health activists. These activists, he wrote, acknowledged the benefits of professional training, but they simultaneously understood that professional expertise was never a neutral category. Because every medical decision was fraught with social and political valences, health radicals believed "that consumers of health care have the right to make socio-political decisions regarding the health care they receive."[442] Community control, then, necessarily meant the ability of community members to "judge, evaluate, and, if necessary, challenge the doctors' technical expertise."[443] Finally, Levy scoffed at Geiger's suggestion that this kind of community control would give rise a community-worker elite. "Geiger exhibits a complete inability to distinguish between the oppressed and the oppressors," he wrote.[444]

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[440] Jack Geiger, "Hidden Professional Roles: The Physician as Reactionary, Reformer, Revolutionary" *Social Policy* 1, no. 6 (1971): 26, Folder 357, Box 48, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.
[441] Jack Geiger, "Hidden Professional Roles," 26.
[442] Howard Levy, "Counter Geiger," *Social Policy* 2, no. 1 (1971): 53. Folder 357, Box 48, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.
[443] Howard Levy, "Counter Geiger," 53.
[444] Howard Levy, "Counter Geiger," 54.

The Geiger/Levy exchange—like so many other debates around the community health program—boiled down to competing definitions of community control. Levy, for the most part, assumed a relatively cohesive "community" that could speak in a united voice. Overlooking divisions within communities, he focused on what he saw as the gulf between communities and professionals. To Levy, Tufts Medical School had "assumed the role of medical missionary in colonial Mississippi."[445] In his telling, "community control" was an attack on the role of the professional and his supporting institutions, a "rallying cry and strategic device used to wrest control of medical care away from white professionals."[446] Medical schools, Levy argued, would never be able to enact real social change. The priority of medical schools was not patient care, but "profits, research, and teaching."[447] As such, they were slaves to their own vested interests: "It did not take medical school empires long to realize that they could reap a bonanza from OEO to operate health facilities in poor communities."[448] For Levy, it was the free clinics run by organizations like the Black Panthers, not the federally funded community health program, that represented the real opportunity for community control, and, thus, social change.

Geiger, on the other hand, did not see the struggle between professionals and the community in such oppositional terms. Communities, he argued, were complex things, often divided by race, class, and social status. The loudest elements, Geiger cautioned, could drown out the others. According to Geiger, professionals should work with the community to identify and channel their voices.

The debate between Geiger and Levy captures the tensions at the heart of the community health center model. Levy's critique of the community health center program represented a

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[445] Howard Levy, "Counter Geiger," 57.
[446] Howard Levy, "Counter Geiger," 57.
[447] Howard Levy, "Counter Geiger," 56.
[448] Howard Levy, "Counter Geiger," 56.

prominent strain of radical thought. The OHA faced similar criticisms from Health/PAC and other health activist organizations. Coming at a time when the OHA was rethinking the role of medical schools in the community health program, this critique appeared especially pertinent. Was the role of the professional inherently at odds with the more egalitarian impulses of community control?

Community Control in Practice

The conflict between Geiger and Levy played out on the ground as well, where community health centers found themselves forging uneasy relationships with the communities they served. Like the black power group that expressed its critique of the Delta Health Center in the *Mound Bayou Voice*, communities often appreciated the presence of the center ("Certainly we want to clinic here and we need it") while also boldly asserting their demands ("THE CENTER AND THE HOSPITAL BELONG TO US").[449] Founded on the ideal of "community control" when neither "community" nor "control" had been well defined, the health centers soon encountered pushback on a number of issues, as local groups, having absorbed and adopted the language of health radicalism, voiced their demands.

The neighborhood health council at the Watts center was especially vocal. Once established, it made a number of demands that seemed to stretch the definition of community control. OEO funds for the Watts center had been distributed to the University of Southern California, which then administered the program in conjunction with the neighborhood council. The council, however, found this arrangement insufficient, claiming that the community should

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[449] Howard Levy, "Counter Geiger," 57.

exercise control over OEO funds, which should be "deposited in a local Negro-owned bank."[450] Similarly, pushing for contracts to be awarded to "local Negro contractors," the council demanded a role in contracts and negotiations, two areas of decision-making that had been mostly assumed by the medical school administrators.[451]

Hiring decisions were also often the subject of intense debate. At Watts, council members insisted that the hiring of all center personnel should require the final approval of the health council. This demand met immediate resistance from USC medical administrators and doctors, who, accustomed to having full control of the hiring process, resented incursions by the non-professional community council. The resulting conflict highlighted the different priorities of the two groups. Both groups expressed their interest in the quality of care at the centers, but they had different ideas about how to achieve it. While the medical schools tended to prioritize traditional professional qualifications when selecting doctors and nurses for the community health centers, council members focused on the professionals' attitude to the community and how they believed they would treat their patients.[452]

The clashes between the community and the professionals at Watts exposed fundamental tensions in the implementation of community control. Even "reform-minded" physicians objected to what they perceived as community infringement into areas of traditional professional control. In a letter to the OEO, Dr. Tranquada at USC wrote of the conflicts at Watts. "The community interpretation of 'maximum feasible participation,'" he complained, "is selectively interpreted as

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[450] Robert E. Tranquada and Elsie A. Giorgi "A Report on the Relationship between the Grantee Institution and The Community Health Council of a Neighborhood Health Center," August 1966, Personal Papers of Dr. Robert Tranquada.
[451] Robert E. Tranquada and Elsie A. Giorgi "A Report on the Relationship between the Grantee Institution and The Community Health Council."
[452] Robert E. Tranquada and Elsie A. Giorgi "A Report on the Relationship between the Grantee Institution and The Community Health Council."

a ‘take over’ rather than a sharing of power.”[453] The only way to resolve these issues, Tranquada argued, was to establish “a clear definition of the areas of lay competence and those areas in which professional authority must predominate.”[454] Tranquada’s letter echoes a recurring question that plagued the community health centers—if communities and professionals held different priorities, whose priorities should take precedence?

Tensions about community control also manifested in internal disputes, where staff often clashed with professionals. As part of their training programs, community health centers drew significant numbers of their staff from the populations served by the centers. The purpose of training programs, as the OHA envisioned them, was twofold. On the one hand, incorporating employment and training opportunities into the health center model would allow the centers to double as a jobs program, providing employment that might help the poor improve their economic situations. On the other, community employment programs would foster community participation by involving local residents directly in the center’s day-to-day operations. Many medical reformers hoped that training programs would have long-term consequences, as the people served by the centers would gradually assume control. John Hatch, for instance, wrote of the community employment program at the Delta Health Center, “In our opinion the long range best hope of providing quality medical care to poor people in the Delta is dependent on our combined efforts toward training and upgrading native sons and daughters committed to making a career in their native land.”[455]

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[453] Robert E. Tranquada and Elsie A. Giorgi “A Report on the Relationship between the Grantee Institution and The Community Health Council.”

[454] Robert E. Tranquada and Elsie A. Giorgi “A Report on the Relationship between the Grantee Institution and The Community Health Council.”

[455] John Hatch, “Letter to Andrew James,” Feb. 17, 1970, pg. 2, Folder 108, Box 14, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

These ideals, however, could be difficult to implement on the ground. The majority of community training programs focused on training for nonprofessional positions. These "nonprofessionals" inhabited an ambiguous space in the health centers. Evaluating the OEO community training programs, Frank Riessman, the director of the New Careers Development Center, wrote,

> Nonprofessional describes what he is *not*, but does not clearly indicate what he is. He is [not] simply a citizen, or a volunteer participating in the organization, although the desire to have him represent the feelings of the neighborhood produces some similarity with the citizen advisory board role of the local resident. He is not the traditional kind of employee because his participation and neighborhood know-how and advice is sought; yet he is also an employee […] He is the new marginal man.[456]

Simultaneously insiders and outsiders, these staff members struggled to represent the community's voice while also working within the health center structure.

At the same time, community hiring practices often resulted in a pronounced inequality within health center staff. While community members populated the lower ranks of the staff, professionals were generally "outsiders" who moved to the area to work at the center. Staff dynamics could often replicate the professional/community dichotomy, and the transience of the professionals compounded tensions between the two groups. One medical student visiting the Delta Health Center wrote that the doctors were "always talking of when they would be leaving."[457] Even with dedicated professionals, an imbalance of power between professionals and the community was unavoidable. As Jack Geiger later pointed out, not only did professionals' "technical expertise" allow them to dominate decision-making, but their ability to "leave and

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[456] Frank Riessman, "Issues in Training the New Nonprofessional," March 1967, pg. 10, Folder 115, Box 15, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[457] David Rashnig, "Community Elective in Mississippi," pg. 6, Folder 86, Box 12, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

work somewhere else on their own terms" put them at a distinct advantage against a community that had no such luxury.[458]

Aware of the problem, many health centers made concerted efforts to recruit black physicians to work in the centers. Geiger, for example, sent letters to the deans of almost 100 medical schools across the country, asking if they had any black students from Mississippi who might be interested in attending a conference at the Delta Health Center. Geiger hoped that a visit to the health center might encourage these students to return "to work in their home area following completion of training, rather than continue the pattern of remaining in urban northern centers."[459] While a few deans responded with the names and addresses of students, most replied that they had no students meeting those criteria. The dean of Boston University School of Medicine, in an effort to help Geiger, replied, "We do not have any black students from Mississippi. The closest we can come is Louisiana."[460] The attempt to recruit black medical students highlighted again the amorphous boundaries of "community." Was recruiting black doctors enough to alleviate tensions between professionals and the community? Could a black doctor from Mississippi straddle the boundary between "professional" and "community"? (And, in the absence of a doctor from Mississippi, would one from Louisiana suffice?)

While medical reformers and OHA administrators hoped that community training and employment would allay tensions between the center and the community, they generally envisioned a gradual handing off of responsibility to community employees. OHA director Dr.

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[458] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 21.
[459] Jack Geiger, "Letter to Deans," Folder 118, Box 16, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.
[460] Henry J. Bakst, "Letter to Jack Geiger," Aug. 3, 1970, Folder 118, Box 16, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

Thomas Bryant, for example, hoped that working together would eventually build trust between the two groups. "If professionals can continue the dialogue," Bryant stated, "they generally discover that consumers and providers become more sophisticated and a better working relationship will evolve."[461] The Delta Health Center, for example, spent significant resources building and training its nonprofessional staff. The nurse Josephine Disparti remembers that, in the early years of the center, community employees were hesitant to take on major responsibility. In training health aides, Disparti had to alleviate their suspicions and "get people to believe that they had a role."[462] After this initial stage, professional/community relationships tended to operate more smoothly.

Relationships at other centers could be more strained. At some health centers, local staff members sometimes sided with community boards in battles for community control, placing increased pressure on medical school administrators. For example, in their evaluation of the OHA health center program, Tufts sociologists Peter Kong-Ming New, Richard Hessler, and Phyllis Bagwell Cater described an "incident" at a community health center in a predominantly black neighborhood in an unidentified Southern city.[463] There, tensions over community control built until they exploded in what the sociologists referred to as a "palace revolution."

This center had struggled to implement OHA mandates of community control. The OHA had given control over the funds to the local medical school, which, in its rush to establish the center, neglected to meet with local residents. The project director later admitted, "We were never asked by the community people to get together and we were rushed by the application

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[461] "Can Community Centers Cure Health Problems of the Poor?" *Journal of the American Medical Association*, 211 no. 12 (1970), 1946.
[462] Interview with Josephine Disparti, New York, New York, June 19, 2016.
[463] Peter Kong-Ming New, Richard M. Hessler, and Phyllis Bagwell Cater, "Consumer Control and Public Accountability," *Anthropological Quarterly* (1973): 197.

deadline. There had not been enough rapport established between us and […] community people."[464] This initial failure to construct a working relationship between professionals and the community led to distrust and skepticism as black community members came to believe that the medical school "does not mean what it says about citizen participation."[465] When the medical school administration belatedly tried to address the community's concerns by hiring a black physician, it again revealed its ignorance of local dynamics, choosing a physician considered to be a "symbol of Uncle Tom."[466]

Tensions at the center climaxed in February of 1970, when eight black staff members, including the center's medical director, met to discuss their grievances. The typed notes from their meeting, which "alluded to weaknesses of some of the programs," later appeared on an administrator's desk and were distributed among the center's staff.[467] When the center's director asked the medical director to explain his grievances, he refused and was fired for "insubordination." Immediately, many of the black staff members responded by declaring a strike.[468] The strike, which came to be known as the "palace revolution" among staff members, provoked outrage among local residents, who sided with the black staff members against the medical school administration. In response to these demands, the administration reinstated the medical director and transferred the director of the health center to a professor position within the medical school.[469]

This "palace revolution" may be an exceptional example, but it shows how the dynamic between professionals and staff members could generate tension. OHA administrators had

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[464] Peter Kong-Ming New, "Consumer Control and Public Accountability," 201.
[465] Peter Kong-Ming New, "Consumer Control and Public Accountability," 201.
[466] Peter Kong-Ming New, "Consumer Control and Public Accountability," 201.
[467] Peter Kong-Ming New, "Consumer Control and Public Accountability," 198.
[468] Peter Kong-Ming New, "Consumer Control and Public Accountability," 198.
[469] Peter Kong-Ming New, "Consumer Control and Public Accountability," 198-199.

envisioned community workers as a bridge to unite professionals with the community, but, just as often, external tensions could manifest as conflicts within the center.

"So Much for Apathy!"

Community training, though often contentious in the short run, could have a positive long-term impact. The Delta Health Center, for example, helped 62 local residents gain technical and professional credentials between 1968 and 1972.[470] One of these residents was L.C. Dorsey, a tenant sharecropper in Bolivar County, whom John Hatch hired as a training associate. While working with Hatch on the health center's farm co-op, Dorsey took classes offered by the Delta Health Center's partnership with the nearby Mary Holmes College.[471] In 1968, a "major crisis" erupted at the co-op when Hatch ignored the community board's vote to purchase fertilizer from the black-controlled Federation of Southern Cooperatives and made a deal with the white-owned Mississippi Chemical Corporation instead.[472] As a result of the incident, Dorsey replaced Hatch as director of the co-op, while Hatch was demoted to an advisory role. After three years as director of the co-op, Dorsey left Mississippi to pursue a master's degree in social work at Stony Brook University in New York.[473] In 1988, after spending a decade in human rights activism, Dorsey returned to Mound Bayou and became director of the health center. Dorsey's life was thus an exceptional example of community training and community control coming full circle.

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[470] John W. Hatch and Eugenia Eng, "Community Participation and Control: Or Control of Community Participation," in *Reforming Medicine: Lessons of the Last Quarter Century,* eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 237.

[471] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 158.

[472] Rudy Frank, "Letter to Girson Green," July 30, 1969, Folder 459, Box 68, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[473] "Dorsey Selected as New Director of Health Center," *Delta Democrat Times*, Folder 260, Box 12, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

Writing about the community health center model, Jack Geiger enthusiastically exclaimed, "So much for apathy! So much for the professional's belief that he has unilateral control of the system!"[474] Indeed, the communities that surrounded the new community health centers were far from apathetic. By the end of the decade, the OHA found itself trying to balance the concerns of professionals and medical schools with the demands of local communities and a growing radical health movement, which tested the limits of the OHA's definition of "community control."

The appeal of community health and community control during the program's early stages had rested in part in their ambiguity. Government bureaucrats, liberal health reformers, activists, and community people themselves had been able to project their own visions on what were vague and amorphous terms. But implementing the model raised two insistent questions: what constituted "authentic" representation, and what did "community control" mean in practice? For the most part, these questions never found satisfactory answers. Community control had not proceeded exactly as reformers like Geiger had planned. Even he and community organizers like John Hatch encountered resistance within the community-run entities they had helped create. Examples like Dorsey, however, suggest that, despite its internal strains and inherent contradictions, community control, even when imperfectly defined, was more than just empty rhetoric. For a few years at least, it formed a key part of the community health center vision.

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[474] H. Jack Geiger, "Of the Poor, by the Poor, or for the Poor: The Mental Health Implications of Social Control of Poverty Programs," *Psychiatric Research Reports* 21(1967): 62.

CHAPTER 5

A Model Under Siege:

The Community Health Center Program in the 1970s

On September 25, 1967, Thurman T. Morgan, a resident of South Carolina, penned a letter to Senator Strom Thurmond after watching a segment on NBC's Today show about the community health center in Watts, Los Angeles. "As I recall," he wrote, "the clinic was built largely with OEO funds; it was originally conceived as a local hospital, but these ambitions had to be scaled down somewhat because of the black-power insistence that it be all-negro. Are we to assume that OEO has authority to construct a hospital exclusively for once race?"[475] Three days later, Senator Thurmond forwarded this constituent's letter to George D. McCarthy, the Assistant Director of Congressional Relations at OEO, requesting a report on the matter.[476] A month later, McCarthy replied, thanking the senator for his "interest in OEO programs" and assuring him that OEO had "received no information that would lead us to believe that the construction or operation of the center has been influenced by Black-Power advocates. Several of the staff members are white and, as with all Federal programs, there is no racial distinction made as to who can be served by this clinic."[477]

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[475] Thurman T. Morgan, "Letter to J. Strom Thurmond," September 25, 1967, Folder CAP Los Angeles Sept-Dec 1967, Box 6, Office of Economic Opportunity, Record Group 381, The National Archives Building in College Park, Maryland.

[476] Strom Thurmond, "Letter to Congressional Liaison, Office of Economic Opportunity," September 28, 1967, Folder CAP Los Angeles Sept-Dec 1967, Box 6, Office of Economic Opportunity, Record Group 381, The National Archives Building in College Park, Maryland.

[477] George D. McCarthy, "Letter to Strom Thurmond," Nov. 4, 1967, Folder CAP Los Angeles Sept-Dec 1967, Box 6, Office of Economic Opportunity, Record Group 381, The National Archives Building in College Park, Maryland.

The united front that the OEO presented in response to these Congressional inquiries, however, belied internal tension. Just two weeks before Morgan had contacted his senator, OEO inspector Eric Biddle had written a confidential memo expressing concerns about the state of the center in Watts, noting, "[OEO officials] are all agreed that the atmosphere surrounding the project is anti-OEO and anti-white." The atmosphere was so tense that OEO administrators debated whether OEO head Sargent Shriver should be present at the center's opening ceremony. "With the atmosphere in Watts today," Biddle wrote, "we cannot exclude the possibility of some sort of embarrassment."[478]

Conflicts over community control were not unusual. In fact, as the last chapter has shown, they were a defining feature of the community health center program. But the center at Watts seemed more precarious than most. There, memories of the riots, the advent of Black Power movement, and a historically strained relationship between the black community and the University of Southern California, combined to form an especially volatile mix.

By 1968, the center appeared to be on the verge of collapsing, with USC and the community in a virtual standoff. Anxious to resolve the situation, USC hired Dr. Rodney Powell, an African-American physician at the California Department of Public Health, as the medical director of the center. Powell had a history of civil rights activism. As a medical student at Meharry Medical College in Nashville, Powell had participated in John Lawson's nonviolence workshops and sit-ins. After graduating from Meharry, Powell signed up with the Peace Corps and spent two years as a doctor in Ethiopia.[479] As medical director, Powell had to earn the trust

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[478] Eric Biddle, "Memo to Edgar May," September 7, 1967, Folder CAP Los Angeles Sept-Dec 1967, Box 6, Office of Economic Opportunity, Record Group 381, The National Archives Building in College Park, Maryland.

[479] David Halberstam, *The Children* (New York: Random House, 1998), 82-83, 463.

of the community council, who viewed him as an outsider and a possible pawn of USC.[480] After a few early struggles, Powell managed to develop a strong working relationship with the community, but he still sometimes found himself at odds with the center's staff. As an integrationist, he was troubled by the growing Black Power movement and its implications of separatism. Powell later recalled an "ugly confrontation" after the death of Martin Luther King Jr. in April 1968. As the center steeled itself in preparation for possible riots, Powell was "stunned" by the questions from some of his staff: "Would the hospital treat whites who were brought in? Should they treat police injured in this forthcoming riot? Some said quite angrily that they had no intention of treating any cops."[481] Powell's argument ultimately prevailed, but he found the episode "disheartening."[482] (One can only imagine what Thurman Morgan and other OEO critics would have thought of the incident.)

At the same time that Powell was trying to hold the various elements of the Watts program together, organizational changes were brewing within OEO as well. In 1969, Dr. Stephen Joseph joined the OHA as the medical director. Like Powell, Joseph had recently returned from the Peace Corps, where he had worked as a doctor in Nepal. Also like Powell, Joseph found himself playing a balancing act. Nixon's 1968 election had cast doubt on the future of War on Poverty programs. In 1969, he named Donald Rumsfeld, a young Congressman from Illinois, head of the OEO.[483] Meanwhile, many OHA officials were beginning to reevaluate some of the decisions they had made in the program's infancy. As the OHA mediated disputes between medical schools, hospitals, and community groups that seemed to be emerging

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[480] Phone interview with Dr. Rodney Powell, April 12, 2017.
[481] Halberstam, 593.
[482] Halberstam, 593.
[483] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick: Rutgers University Press, 2007), 201.

at health centers across the country, many of these administrators wondered whether institutions like medical schools were fundamentally capable of accomplishing the sort of social reform they had envisioned.

Powell and Joseph's paths intersected in 1969, when, shortly after Joseph had started at OEO, Powell brought him a proposal to change the OEO grant to make the community-run governing board, rather than USC, the official grantee. After considering the proposal, Joseph "decided that this was a good idea" and approved the change.[484] The shift at Watts marked a new phase of the community health center program. As previous chapters have detailed, early grants tended to go to medical schools and hospitals, which had the resources and infrastructure to take immediate advantage of federal money.[485] Joseph's decision, however, proved to be a significant turning point in OHA policy. After the grant at Watts was transferred to the community governing board, other communities clamored to follow suit.

In some ways, the transfer of the OEO grant to Watts seemed to suggest the epitome of "community control." After all, after battling professionals for final authority, communities were finally taking the reins of their community health centers. However, this chapter will argue that the results were far more complicated. In fact, the reign of "community control" was brief. Just as the OHA began to transfer control of centers to community agencies, a shift in national politics eroded the radical edge of the community health center program. With President Nixon's election, political discourse shifted, setting new standards of success for the program. The language of community control—so dominant just a few years prior—was quickly supplanted by the language of consumers and fiscal self-sufficiency, to the detriment of some of the reformers'

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[484] Phone interview with Dr. Stephen Joseph, May 17, 2016.

[485] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 16.

more far-reaching visions. Community boards found themselves in charge of projects whose focus had greatly narrowed. The changes were gradual, but, by 1974, the community health center program was transferred from the OHA to the mainline bureaucracy in Health, Education, and Welfare, marking a definitive shift as the centers—once under the oversight of a small and fairly exceptional group of federal officials—were parceled out to various regional offices.

This chapter traces the evolution of the community health center concept at the end of the 1960s and studies the way in which community health centers adapted to the new political era. Scholars of the community health center program have varied widely in their interpretations of these years, with some painting much rosier pictures than others.[486] I argue that this discrepancy is due to a peculiar irony. Just as the elusive goal of "community control" seemed within reach, the reformers' vision of a community health center as a tool for social change was fading quickly.

Giving Control to the Community

By 1969, when Powell approached Joseph about transferring the Watts grant, the OHA had been growing increasingly dissatisfied with their relationships with medical schools. Medical schools had played an important role in the program's early days. With an influx of funding but few ideas, the OEO had sought the leadership of medical schools and hospitals. Just a few years later, however, OHA administrators worried the institutions had outlived their

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[486] The political scientist Richard Couto, for example, ends his chapter on the community health program on a high note, claiming that HEW maintained many of the key features of the community health program. The historian Jenna Loyd, on the other hand, writes that the political changes of the late 1960s "foreclosed" the "radical possibility" of community health. These two scholars do not necessarily contradict each other, but both evaluate the program against different measures of success, presenting very different assessments. Richard A. Couto, *Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South* (Philadelphia: Temple University Press, 1991), 282-285; Jenna Loyd, *Health Rights Are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: The University of Minnesota Press, 2014), 202.

usefulness. Many OHA officials had understood their relationship with medical schools as a convenient, but temporary, arrangement, and they vaguely envisioned a point where community boards could take over control. However, it soon became clear that medical schools did not necessarily share such a vision. Medical schools that received OEO grants for community health centers frequently established new departments of community medicine. On the one hand, these departments seemed to signal a commitment to the centers, but, at the same time, the new departmental infrastructure seemed to suggest that the medical schools saw their involvement as more than just temporary.[487]

Meanwhile, the battles over community control at health centers across the country appeared to highlight the shortcomings of the arrangement, placing pressure on OHA to resolve these tensions. In January 1969, the relationship between Tufts and the Columbia Point Health Association Board had deteriorated to the point where OHA hired an arbitrator from American Arbitration Association to resolve the conflict.[488] Another conflict at health center in Pittsburgh brought the problem directly to the OHA's doorstep. John Frankel, the director of the OEO's Community Action Program, later recalled an incident in which a group from Pittsburgh stormed his office, demanding that their choice for project director be approved:

> "They completely surrounded my desk and my conference table, and they stood behind me lining the walls. I finally screamed for Joe English to come down. Joe came and sat down. And I said, 'I'm chairing this meeting, and I am not going to talk until you guys sit down, because we are going to talk.' And they never sat down. Joe took over. We were both terrified and I mean terrified."[489]

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[487] As Rodney Powell later noted, communities often viewed these departments "with suspicion," seeing them as examples of medical schools' ulterior motives.
Rodney Powell, "A Case Study for Consumer Planning in Health Care Services: Tokenism, Neo-Colonialism, Trust, and Corporate Practice," *Symposium on Decision-Making and Control in Health Care* (New York: New York Academy of Medicine, 1971), 13-15.

[488] Richard A. Couto, *Ain't Gonna Let Nobody Turn Me Round*, 280.

[489] Richard A. Couto, *Ain't Gonna Let Nobody Turn Me Round*, 280.

Violence was a real possibility. In Lowndes County, Alabama, after the OHA had intervened to overhaul the struggling program, the FBI alerted the OHA of plans to kill OHA staff member Wendy Goepel. (The OHA promptly recalled Goepel from the county.) At another community health center in East Los Angeles, OHA members were shot at after exiting a meeting.[490]

Medical schools not only appeared ill-equipped to deal with these conflicts, but their leadership also seemed to present a structural obstacle to community control. In 1968, former OHA heads Lisbeth Bamberger and Joseph English expressed regret over their early decision to hand an outsized role to medical schools, writing, "We did not fully appreciate that the requirement of full participation by those being served after a proposal had been approved could never make up for the fact that the project had been originated and formulated by professionals alone."[491] Privileging the providers over the patients, they now reasoned, undermined the very notion of community control.

Thus, when Powell approached Joseph in 1969 and requested that the grant be directed through the community board, OHA officials welcomed the suggestion. As Joseph later remembered, there was "a lot of sympathy" for Powell's request, which seemed like the natural solution to conflict over community control.[492] With little pushback within the OEO, Joseph's decision with Watts marked a major policy shift for the OHA away from medical schools as to community governing boards as grantees. Whereas medical schools had received 37 percent of the initial health center grants in 1965 and 1966, by 1971, only 7 percent of OEO grants went

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[490] Interview with Dorothy Mann, June 28, 2016, Seattle, Washington.

[491] Lisbeth Bamberger Schorr and Joseph T. English, "Background, Context and Significant Issues in Neighborhood Health Center Programs," *The Milbank Memorial Fund Quarterly* 46, no. 3 (July 1, 1968): 292.

[492] Phone Interview with Dr. Stephen Joseph, April 10, 2017.

to medical schools and 10 percent to hospitals. A majority of grants—59 percent—went to community-run corporations.[493]

OHA officials may have welcomed the change, but the reaction from medical schools was mixed. In the case of Watts, Powell encountered little resistance from USC. By 1969, the school was looking to cut its losses. Though skeptical of the community council's ability to operate the center, USC was generally relieved to relinquish control of the center and the conflict that came with it.[494] Others, however, found the shift more difficult. According to Joseph, "It was about power and it was about money. It was painful for a lot of people […] to let it go."[495] In some cases, medical schools had devoted considerable resources to the programs. Having established departments of community medicine to run the centers, medical schools often depended upon OEO funding for their overhead costs. The process, then, was a gradual one. In centers throughout the country, the OHA worked with community health councils, helping them acquire the necessary training so that they could assume control as full-fledged governing boards.

Changes in Mound Bayou

Reformers like Geiger also had difficulty with the shift. During the early years of the program, Geiger's goals had seemed to align very closely with the OEO's. The OEO's eagerness to move away from university grantees, however, caused a fissure in the relationship. Since its opening, the Delta Health Center had found itself in the midst of a local power struggle. The all-black town of Mound Bayou was home to two hospitals, both run by black fraternal organiza-

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[493] Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change" in *Reforming Medicine: Lessons of the Last Quarter Century,* eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984), 19-20.
[494] Phone interview with Dr. Rodney Powell, April 12, 2017.
[495] Phone interview with Dr. Stephen Joseph, May 17, 2016.

tions that offered hospital insurance to their members.[496] These hospitals provided health care to a population that local white physicians refused to see, and they resented the OEO and Tufts' intrusion. Geiger, however, hoped to avoid entanglement with the hospitals. Not only was the quality of their care subpar, he claimed, but they were also more interested in profiting off of the poor than in serving them. In an effort to appease the fraternal organizations, Geiger and other Tufts staff members helped the hospitals apply for an OEO grant to merge the two facilities into the Mound Bayou Community Hospital, but they resisted all efforts to merge this community hospital with the Delta Health Center.[497]

Tensions between the health center and the hospital persisted. In 1968, Mound Bayou's black mayor, Earl Lucas, and his allies unexpectedly arrived at the OEO's Washington, D.C., headquarters, demanding that the hospital be merged with the health center. The OHA director Joe English contacted Geiger, who, immediately flew to D.C. Livid, he told OEO officials, "You are destroying us, and you need to understand something about who these people are."[498] Geiger was able to convince English that the Mound Bayou elite did not represent the community. The center avoided a merger, but Lucas and his fellow city officials continued to

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[496] The International Order of Twelve Knights and Daughters of Tabor opened the Taborian Hospital in 1942. In 1948, a splinter group from that organization, called the United Order of Friendship, opened the competing Friendship Clinic. Greta De Jong, "Plantation Politics: The Tufts-Delta Health Center and Intraracial Class Conflict in Mississippi, 1965-1972," *The War on Poverty: A New Grassroots History, 1964-1980*, eds. Annelise Orleck and Lisa Gayle Hazirjian (Athens: The University of Georgia Press, 2011), 260.

[497] Greta De Jong, "Plantation Politics: The Tufts-Delta Health Center and Intraracial Class Conflict in Mississippi, 1965-1972," *The War on Poverty: A New Grassroots History, 1964-1980*, eds. Annelise Orleck and Lisa Gayle Hazirjian (Athens: The University of Georgia Press, 2011), 261.

[498] Thomas J. Ward Jr., *Out in the Rural: A Mississippi Health Center and its War on Poverty* (New York: Oxford University Press, 2017), 147.

hound the center, threatening it with "town taxes," and, at one point, discussing building a "sewage lagoon" next door.[499]

The merger issue resurfaced in 1970, when Geiger left Tufts to accept the position of chair of community medicine at SUNY Stony Brook. Faced with this shift, Tufts presented the community health council with several options: it could stay with Tufts, it could follow Geiger to Stony Brook, it could choose another medical school as a sponsor, or it could incorporate and received OEO funds directly. A number of medical schools had expressed interest in sponsoring the now well-known center, and the health council went on a series of "reverse site visits," sending representatives to Tufts, Stony Brook, the University of Wisconsin, and Meharry Medical College to see what those institutions could offer the center.[500] Ultimately, the council voted to follow Geiger to Stony Brook, a move vehemently contested by Lucas and his allies. In a scathing article, the *Mound Bayou Voice* condemned the decision, writing, "The people of the center do not yet realize that the center belongs to them, and not 'Mr. Tufts.' The overwhelming majority of the consumers are still revolving in the plantation cycle of life where you accept what is given and dare not ask for any more and are not encouraged to do so."[501] Echoing the language of the Black Power movement, they proclaimed, "Blacks do not need whites to think for blacks […] NO white can be allowed to choose the black leader any more."[502]

The center had avoided the merger with Mound Bayou Hospital yet again, but it would not be for long. In 1970, the OEO, then engaged with transferring its grants from medical schools to community boards, had begun to hint that such a merger might be desirable. The health council's

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[499] Thomas J. Ward Jr., *Out in the Rural*, 140.
[500] Thomas J. Ward Jr., *Out in the Rural*, 151.
[501] Greta De Jong, "Plantation Politics: The Tufts-Delta Health Center and Intraracial Class Conflict in Mississippi, 1965-1972," 269.
[502] Greta De Jong, "Plantation Politics: The Tufts-Delta Health Center and Intraracial Class Conflict in Mississippi, 1965-1972," 269.

vote to move the grant to Stony Brook postponed the merger temporarily, but, soon after, the OHA was beginning to discuss the possibility more openly.[503] As the OHA looked to move away from university sponsorship, it found the language of self-determination and Black Power increasingly compelling. Merging the center with a local black hospital and eliminating the medical school's role seemed like the natural extension of the process that Joseph had started in Watts. At the same time, turnover within the OHA meant that fewer officials there were as familiar with the long-standing battles between the center and the hospital.

In January 1972, shortly after Stony Brook had assumed sponsorship of the center, Geiger received a call from OEO, demanding an "immediate merger of the Health Council and the Hospital Board" and the "elimination of Stony Brook (or any other university) as grantee.[504] Though the idea of a merger had been bandied about for some time, the accelerated timetable came as a shock, both to Geiger and some within the OEO. According to Geiger, program analyst Dorothy Mann told him that the decision was a sudden "change in signals"; nevertheless, OEO would no longer fund the university grantee.[505]

Geiger, who had resisted a merger for years, was furious with the sudden announcement. Finalizing a merger within a couple months, he argued, was not only "totally unrealistic," it also

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[503] Jack Geiger, "Brief History of the Delta Health Center 1970-1972, and of the Events Leading to Merger with the Mound Bayou Community Hospital in a New Corporation Beginning March 1, 1972," Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[504] Jack Geiger, "Brief History of the Delta Health Center 1970-1972, and of the Events Leading to Merger with the Mound Bayou Community Hospital in a New Corporation Beginning March 1, 1972," Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[505] Jack Geiger, "Report on H. Jack Geiger's Trip to Delta Health Center," January 13, 1972, pgs. 6-7, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

"inevitably sealed the doom of the Health Center."[506] Criticizing the merger, Geiger argued that the elites who ran the Mound Bayou Hospital, though black, did not represent the community served by the health center, which was largely poor and rural. "Brooks-Lucas-etc. in Mound Bayou is <u>not</u> the black community," Geiger wrote, "the black community is all the poor in and particularly outside of Mound Bayou who have been shut out of control and now inevitably of their health services as well."[507] Placing control of the health center into the hands of the elites—or, as Geiger called them, the "Mound Bayou Mafia," was not the embodiment of community control, but rather a capitulation to the local power structure.

While the Mound Bayou Hospital had included some provisions for "community control" to comply with OEO standards, Geiger argued that these concessions had been largely nominal. The hospital had held elections for a community board, but "only a handful of people participated in or even knew about the hospital elections."[508] In contrast to the health center, which had built up community support through grassroots health associations, the hospital had only adopted the veneer of community control. The merger proposal, according to Geiger, left these insufficient by-laws "virtually intact": "The only provision is for an annual election—based on no structured community organization—to be held at unspecified sites 'with the poles [sic] open at least two

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[506] Jack Geiger, "Report on H. Jack Geiger's Trip to Delta Health Center," January 13, 1972, pg. 9, 10, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[507] Jack Geiger, "Confidential Memo to Mike Holloman," July 19, 1973, pg. 2, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[508] Jack Geiger, "Letter to Dorothy Mann," March 13, 1972, pg. 3, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

hours.'"[509] By adopting the hospital's loose standards of community control, Geiger warned, the merged institution would lose any connection or accountability to the community.

Geiger's argument thus invoked the recurring question over what constituted community control, rehashing a debate that had persisted since the beginning of the community health center program. Moving away from a university grantee, Geiger contended, did not necessarily mean community control. In fact, if handed over to local elites, community health centers might actually move farther away from this ideal. The OHA's policy shift highlighted the growing differences between the OHA and medical reformers like Geiger, who were often tied to medical schools. Though both had united over the common cause of community health, their alliance now seemed to be fracturing.

New Federalism and the Community Health Centers

At the same time that the OHA was beginning to transfer community health centers to community boards, another major change was looming. Republican opposition to the OEO, particularly the OEO's focus on maximum feasible participation and community control, had been brewing since the agency's beginning. "Maximum feasible participation" had appeared relatively benign during the Congressional debates over the Economic Opportunity Act, but, as early as 1966, the idea of community control had gained a number of political enemies. In their 1966 midterm election campaigns, many Republican representatives pointed to community action as a failed policy, charging that it was stoking the fires of racial disorder in cities.[510] In 1967, the House Education and Labor Committee convened a hearing on amendments to the

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[509] Jack Geiger, "Letter to Dorothy Mann," March 13, 1972, pg. 2-3, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[510] Alyosha Goldstein, *Poverty in Common: The Politics of Community Action During the American Century* (Durham: Duke University Press, 2012), 131.

Economic Opportunity Act. Hearing testimony from city officials who charged that OEO community action programs had been "commandeered by radicals," Congress delayed appropriations to the community action programs.[511] The community action program barely survived. Appropriations passed only after Congresswoman Edith Green—in a move meant to dilute the maximum feasible participation clause—added an amendment that gave local officials more control over community action agencies in their districts.[512]

Senator Thurmond's letter to the OHA notwithstanding, the community health centers had been somewhat insulated from these attacks on community action. Operated mostly by medical schools and teaching hospitals, they were not what most Republicans had in mind when they thought of radicals, riots, and racial disorder. OEO officials, for their part, tried to avoid the most overt political activities in order to elude Congressional scrutiny, regularly conducting audits to ensure health center funds were not used for "illegitimate" uses, though the lines between "community control" and an "illegitimate political activity" could be blurry.[513] Thus, though the community health center program had roots in the OEO's community action program, it was, as the political scientist Alice Sardell later noted, "not viewed as a politically radical

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[511] Alyosha Goldstein, *Poverty in Common: The Politics of Community Action During the American Century* (Durham: Duke University Press, 2012), 131.

[512] This amendment had little impact. A year later, Green herself later argued that the OEO had found ways to circumvent the amendment and was conducting "business as usual."
Roger H. Davidson, "The War on Poverty: Experiment in Federalism, *The Annals of the American Academy of Political and Social Science* 385, no. 1 (1969): 8.

[513] In 1972, for example, the Delta Health Center faced criticism over the charge that it had used its cars (meant for transporting patients) to transport voters to the polls on election day. The charges resulted in pressure within the OEO to close the center, but the OEO director refused and instead ordered an audit to deflect political pressure. Roger Cohen, "Letter to Dr. Pellegrino," April 7, 1972, Folder 86, Box 12, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

experiment but rather as a professional and 'charitable' enterprise."[514] As such, it was mostly unacknowledged during the 1967 Congressional debates. When it was briefly mentioned, it was not grouped with the more controversial community action programs, but instead described as "bringing medical care to people who have not seen a doctor or a dentist in their lives."[515]

Though the OHA managed to survive Republican opposition to community control and "maximum feasible participation" mostly unscathed, it was a bit more vulnerable to attacks from organized medicine. As discussed in Chapter 4, in response to lobbying from the American Medical Association (AMA) and private practitioners, Congress passed a 1967 amendment to the Economic Opportunity Act requiring the health centers to limit their services to "low-income" residents. Though the shift was subtle (the centers had been serving mostly poverty-level populations before the amendment passed), the implications were deeper. Reformers had envisioned a community health center program that abolished the traditional distinction between private medicine and public health, but, with the amendment, Congress ensured that the division between the two would remain.[516] The amendment affected the operation of the centers only minimally, but it chipped away at the program's radical vision.

After its success in pushing through the 1967 amendment, the AMA generally had little to say on the community health center program. Compared to Medicare and Medicaid, the program was low on organized medicine's list of priorities, and, once it was limited exclusively to poor populations, the program posed very little threat to private practitioners.[517] With little

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[514] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1968* (Pittsburgh: University of Pittsburgh Press, 1988), 67.
[515] Sara Santana, "The View from the Community," *Health/PAC Bulletin* 12, 22.
[516] Alice Sardell, *The U.S. Experiment in Social Medicine*, 64.
[517] Alice Sardell, *The U.S. Experiment in Social Medicine*, 92-93.

resistance from Republicans and the AMA, the community health center program continued to expand through the late 1960s.

Nixon's election, however, shifted the political calculus. The 1960s had witnessed a major acceleration in the expansion of the federal government, as Great Society programs shifted control of areas previously considered "local" to the federal government. By the end of the decade, this expansion was meeting increased resistance from conservatives.[518] Taking office in 1969, Nixon promised to reverse this trend, announcing plans to reform the intergovernmental system through a new approach to governance, which he dubbed "New Federalism." Though billed as an alternative to the War on Poverty, New Federalism, was not, in fact, anti-welfare state. As the political scientist Timothy Conlan points out, Nixon's proposals were aimed at rationalizing and restructuring the welfare state, not eliminating it.[519] New Federalism had two major components. On one hand, Nixon planned to nationalize a few programs for the sake of "efficiency." On the other, he planned to use block grants and revenue sharing to devolve other responsibilities to the state and local levels.

New Federalism posed a threat to the community health center program. Though, as the historian Jenna Loyd has pointed out, New Federalism appeared to share some "superficial resonances with 'community control,'" there was an enormous difference between the OEO's conception of community control and New Federalism's emphasis on "local control."[520] While community control entailed "authentic" community representation by poor people themselves,

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[518] Timothy Conlan, *New Federalism: Intergovernmental Reform from Nixon to Reagan* (Washington, D.C.: The Brookings Institute, 1988), 6.

[519] Timothy Conlan, *New Federalism: Intergovernmental Reform from Nixon to Reagan* (Washington, D.C.: The Brookings Institute, 1988), 6.

[520] Jenna Loyd, "Where Is Community Health? Racism, the Clinic, and the Biopolitical State," *Rebirth of the Clinic: Places and Agents in Contemporary Health Care,* ed. Cindy Patton (Minneapolis: University of Minnesota Press, 2010), 56-57.

local control meant state or local officials, an established power structure that the OEO had generally sought to avoid. In fact, the OEO's notion of community control had relied heavily on centralized federal authority to protect the centers from sometimes hostile state officials. Though the Economic Opportunity Act had given governors veto power over centers in their states, the OEO director had the power to override this veto.[521] In many Southern states, this protection had been a crucial factor in the centers' survival. New Federalism threatened to upset this delicate balance of power by making community health centers more vulnerable to local whims. As James Bivens, the director of the Delta Health Center, explained, "When you start talking about giving more control of federal money to local governments you are actually talking about creating a whole different concept of patronage. With OEO, poor people had control over budgets and federal programs at the state level. What Nixon is talking about now is giving local politicians those same funds and letting them decide where or not to continue programs like ours."[522]

In keeping with these goals to reform the welfare state, shortly after taking office, Nixon announced plans to "revamp" the OEO.[523] Nixon's plan, which called for the OEO's existing programs to be either eliminated or "spun off" to the relevant mainline bureaucracy, drastically shrunk the OEO's sphere of influence. The OEO would survive, but it would take on a very different shape, acting solely as an "an incubator for new programs," or, as one writer for *Black Enterprise* would put it a few years later, "the research and development arm of the executive

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[521] Martha J. Bailey and Nicolas J. Duquette, "How Johnson Fought the War on Poverty: The Economics and Politics of Funding at the Office of Economic Opportunity." *The Journal of Economic History* 74, no. 02 (2014): 357.
[522] Joseph Huttie Jr., "New Federalism and the Death of a Dream, in Mound Bayou, Mississippi," *New South* 28, no. 4 (1973): 25.
[523] O'Connor, 222-223.

branch of the government."[524] To direct this process, Nixon appointed Donald Rumsfeld as head of the OEO. Rumsfeld, in turn, hired Dick Cheney—then a young Congressional staff aide—as his special assistant, and the two began the process of dismantling the War on Poverty bureaucracy.[525]

For the OHA, this "spin off" plan meant that the community health centers already in operation would be transferred to HEW, thus consolidating all the federal government's health activities under one department. The first few years of Nixon's administration were thus a transition period for the community health centers. On one hand, the OHA began the process of transferring the centers to HEW, divesting itself of the operating responsibility it had clung to during the War on Poverty. On the other, the process of transferring was gradual, and, meanwhile, the OHA was mostly operating as normal. Rumsfeld, for example, proved surprisingly sympathetic to OHA's goals. After visiting the community health center in Denver, he became convinced him of the importance of the program.[526] Dr. Stephen Joseph, head of the OHA under Rumsfeld, later remembered that Rumsfeld "did very little to interfere with the evolution of the program."[527] Even Dick Cheney, he recalled, was well-liked within OHA, proving to be a useful resource and "a great asset to us."[528]

The transfer process was eased by the fact that HEW itself had changed dramatically over the preceding few years. Though the Public Health Service (PHS), a division of HEW, had been established in the late nineteenth century, its activities for the first half of the twentieth century

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[524] Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1968* (Pittsburgh: University of Pittsburgh Press, 1988), 77-78; James Williams, "The Big Gun in the War on Poverty Didn't Die, Just Faded Away," *Black Enterprise* 3 (1973): 27.
[525] Bonnie Lefkowitz, *Community Health Centers*, 297.
[526] Richard A. Couto, *Ain't Gonna Let Nobody Turn Me Round: The Pursuit of Racial Justice in the Rural South* (Philadelphia: Temple University Press, 1991), 282.
[527] Phone Interview with Dr. Stephen Joseph, April 10, 2017.
[528] Phone Interview with Dr. Stephen Joseph, April 10, 2017.

had been fairly limited. In the early 1960s, for example, the PHS had funded state programs to treat specific diseases, but it had always maintained the traditional separation of private medicine and public health.[529] In 1968, however, the PHS blurred that line, funding comprehensive health centers that echoed the model pioneered by the OHA. Over the next two years, HEW funded 24 centers.[530] In her history of the community health center program, Alice Sardell attributes this sudden change in the PHS to "policy entrepreneurs" in HEW.[531] Just like the OEO, HEW in the late 1960s had become a magnet for a new breed of reform-minded physicians, benefitting from federal laws that allowed doctors to complete a two-year stint in the PHS as an alternative to military service. While many of these physicians went to the OHA after completing their two years (as Chapter 3 has shown), a number moved to other positions in PHS/HEW. By the end of the decade, therefore, both the OHA and HEW were home to "socially concerned" physicians interested in breaking down the traditional barriers between private medicine and public health.[532] As Sardell notes, these commonalities facilitated "a lot of interaction and discussion" between the two agencies.[533]

The web of relationships connecting the two agencies helped the process operate relatively smoothly. In 1971, when Dr. Joseph began the gradual process of transferring the community health centers, the administrator of Health and Services and Mental Health Administration in HEW was Dr. Joseph English, the former medical director of OHA. English's assistant was Dr. Stanley Scheyer, a former medical director of the Peace Corps. Joseph called Scheyer his "twin" at HEW. He had followed a similar path as Joseph, landing at HEW instead of OHA. Working

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[529] Alice Sardell, *The U.S. Experiment in Social Medicine*, 68.
[530] Alice Sardell, *The U.S. Experiment in Social Medicine*, 68.
[531] Alice Sardell, *The U.S. Experiment in Social Medicine*, 69-70.
[532] Alice Sardell, *The U.S. Experiment in Social Medicine*, 70.
[533] Alice Sardell, *The U.S. Experiment in Social Medicine*, 70.

together, Scheyer and Joseph initiated the transfer process, negotiating which centers would be transferred first. As Joseph later recalled, the process "would have been messy with a different cast of characters."[534]

While these similarities and connections made the process somewhat easier, OHA staff were still loath to relinquish control over their projects. Program analysts, who had functioned as liaisons between the community health centers and the OHA bureaucracy, had developed direct relationships with the centers, and many tried to cling to their "babies" for as long as possible.[535] For the most part, OHA staff tried to transfer the most well-established centers first. These centers, they reasoned, would be best able to adapt and survive the change in leadership. However, they simultaneously tried to hold onto a handful of "showcase" centers. Not only were many staff members personally proud of their work with those centers, they also hoped to prolong the OHA's relevancy by maintaining these constituencies.[536] The Delta Health Center in Mound Bayou, for example, was one of the last to be transferred.

The regional structure of HEW further complicated the transfer. Whereas OHA consisted of a highly centralized core staff in Washington, HEW operated through its regional offices throughout the country. The community health centers, then, would be handed off not just to HEW, but to the specific offices that governed their regions. For OHA analysts concerned about the future of these centers, not all regional offices were equal. While recent changes in PHS/HEW leadership had made the department a more welcoming home for the community health center program, these changes had not necessarily trickled down to regional offices. The

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[534] Phone Interview with Dr. Stephen Joseph, April 10, 2017.

[535] Phone Interview with Dr. Stephen Joseph, April 10, 2017.

[536] Richard Hessler and Carolyn Beavert, "Citizen Participation in Neighborhood Health Centers for the Poor: The Politics of Reform Organizational Change, 1965-77." *Human Organization* 41, no. 3 (September 1, 1982): 250.

health center in San Luis, Colorado, for example, served a population that bordered two regional jurisdictions—one administered by the Denver office and the other by the Dallas office. OHA fought for the center be handed to the Denver office, whose staff they trusted to uphold the values of "community control." Instead, the center was given to the Dallas office, where, as one analyst later recalled, it went "to hell in a hand basket."[537]

Health center staff also struggled with the shift, and some resisted the move to HEW. Having established relationships with program analysts at OHA, many medical directors worried about the changes that might come with a move to a new agency. Program analyst Sarah Atkeison, for example, remembered that analysts were forbidden from informing center directors when the centers were about to be transferred. The confusion could lead to tension. For example, the medical director of the health center in Sunset Park, Brooklyn, who had previously formed a close working relationship with Atkeison, was "furious" when he discovered the center was to be one of the first transferred to HEW.[538]

The transfer of the community health program to HEW, though painful for many OHA staff members and health center staff, did not spell the end of the community health program. Even as they handed off programs to HEW, the OHA still enjoyed a great deal of autonomy. In fact, during the early years of Nixon's first term, the program continued to grow.[539] One OEO analyst noted,

> "You would have thought that…it would have been reasonable to predict that under a Republican administration, concerned with OEO style and concerned with OEO's image in American society, that the health programs and the other programs would rapidly go someplace else. Instead of that, what happened in 1969 was that the OEO health program had a second period of growth with almost a completely different set of actors…Because Rumsfeld decided, and in some ways, Shriver

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[537] Phone Interview with Lucia Hatch, July 12, 2016.
[538] Interview with Sarah Atkeison, Albuquerque, New Mexico, June 26, 2016.
[539] Bonnie Lefkowitz, *Community Health Centers*, 297-298.

> had decided, that health was a good program to play. A lot of the logic was much the same. Nobody was going to get mad at Rumsfeld for expanding a health program."[540]

Once again, the community health center program survived by distancing itself from more "radical" community action programs. The community health center program had always straddled the boundary between a poverty program and a health program. Now, as the War on Poverty was increasingly maligned, this dual identity proved politically crucial.

The Second Nixon and the Battle of Fiscal Austerity

In her history of the community health centers, Bonnie Lefkowitz divides Nixon's presidential terms into "the two Nixons." While the New Federalism that Nixon announced shortly after his first inauguration threatened to destabilize the community health center program by reordering the federal bureaucratic structure it relied upon, these early policies were not generally anti-welfare state.[541] Moreover, Nixon and Rumsfeld seemed, at the very least, to be receptive to the idea of the community health center program. Even as the centers were being transferred from OHA, the program continued to grow.

Nixon's second term, however, signaled a decisive rightward turn. After Rumsfeld had left his position in 1970, he had been succeeded by his executive director Frank Carlucci, under whose direction the OHA had operated mostly as usual. But in 1973, Nixon made a move to dissolve the agency, appointing Howard J. Phillips, a conservative who was openly opposed to the OEO's community action programs, as director.[542] Revealing a broad plan to dismantle the

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[540] Richard Hessler and Carolyn Beavert, "Citizen Participation in Neighborhood Health Centers for the Poor: The Politics of Reform Organizational Change, 1965-77." *Human Organization* 41, no. 3 (September 1, 1982): 249.

[541] Bonnie Lefkowitz, *Community Health Centers*, 15.

[542] Sara Diamond, *Roads to Dominion: Right-Wing Movements and Political Power in the United States* (New York: Guilford Press, 1995), 116.

OEO, Phillips announced, “We propose to eliminate the middleman—the antipoverty bureaucrat—and see that the money intended for the poor really goes to their direct benefit. The old approach of trickling down dollars for the poor through a vast array of poverty contractors and professionals has only alleviated poverty for the middlemen.”[543] Phillips’ statement undercut the very reasoning behind the OEO, and, indeed, behind the War on Poverty in general, which had funneled money for the poor through a host of new social programs. In doing so, he relied on the logic of fiscal efficiency. The problem, as he put it, was not that the government was spending too much money, but, rather, that not enough of that money was able to “trickle down” to the poor people themselves.

Phillips only served as head of OEO for a brief time. A few months into his tenure, a federal judge ruled his appointment void because Nixon had not sought or obtained Congressional approval, and Phillips was forced to resign.[544] However, his appointment had signaled a new stage for the health centers. In 1972, the Nixon administration had begun to phase out federal grants for community health centers. In May 1973, new HEW regulations imposed a new financial burden on the community health center program, requiring community health centers to maximize funding from sources outside federal grants. Community health centers, an attached announcement read, “must be or become self-sustaining, community-based operations.”[545]

The transfer to HEW had been difficult for many community health centers, but this proposed standard of self-sufficiency threatened to eliminate them altogether. Making use of outside funds had long been the goal of OHA staff and community health center reformers, but it

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[543] “Extensions of Remarks,” May 22, 1973, 93rd Cong., 1st sess., *Congressional Record*, 119, pt. 13:16633.
[544] Sara Diamond, *Roads to Dominion: Right-Wing Movements and Political Power in the United States* (New York: Guilford Press, 1995), 116.
[545] Alice Sardell, *The U.S. Experiment in Social Medicine*, 80.

had been elusive. As Dan Zwick, the executive officer of OEO's health division, wrote in a 1972 article, "The initial OEO grant support of health centers assumed that long-term financial support would come largely from Medicare and other financing sources."[546] This assumption seemed reasonable in the mid-sixties. Medicare and Medicaid were brand new, and health reformers could envision a time when they might cover most patients served by the community health centers.[547] By the end of the decade, however, this goal was still far from reach. While Medicare, administered by the federal government, was uniform nationwide, Medicaid, which relied on a combination of federal and state funding, still lagged in many states. This uneven patchwork meant that centers in states where Medicaid funding was meager (often in the South) had difficulty extracting reimbursements for the services they provided.[548] Furthermore, community health centers often served broad populations, not all of whom qualified for Medicare or Medicaid assistance. Dr. Effie Ellis, the special assistant for health services to the Executive Vice-President of the AMA, estimated that in 1970, only one-fourth of the "medically indigent" met the requirements to receive Medicare or Medicaid.[549]

Writing in 1970, Dr. Thomas Bryant, then the director of OHA, remarked that, though the model of the community health center had proven successful, financing was still a problem. "The new financing efforts," Bryant wrote, "have not fulfilled their aspirations and promise."[550] Finding Medicare and Medicaid often insufficient, most community health centers were still

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[546] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *The Milbank Memorial Fund Quarterly* 50, no. 4 (1972): 407.

[547] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," 407.

[548] George A. Goldberg, Frederick L. Trowbridge, Robert C. Buxbaum, and Joyce C. Lashof, "Issues in the Development of Neighborhood Health Centers," *Inquiry* (1969): 43.

[549] "Can Community Centers Cure Health Problems of the Poor?" Medical News. *JAMA.* 1970; 211(12):1955.

[550] Thomas E. Bryant, "Goals and Potential of the Neighborhood Health Centers," *Medical Care* 8, no. 2 (1969): 94.

relying heavily on federal funds in the early 1970s. In this context, the Nixon administration's calls for self-sufficiency, though cloaked in the rhetoric of efficiency, seemed to spell the end of the community health center program.

Efforts to eliminate federal funding for community health centers, however, were met with strong opposition from a Democratic Congress. Senator Ted Kennedy, chair of the Senate Health Subcommittee, and Congressman Paul Rogers, chair of the House Health Subcommittee, led the charge to save the program's federal funding.[551] Kennedy called for the Government Accountability Office (GAO) to examine the effect of Nixon's proposed policy of self-sufficiency. The study, released in 1973, concluded that, without federal funding, the community health center program would need to be dramatically scaled back: "If the centers must rely on insurance payments to survive, they will have to eliminate many existing health services."[552] After several meetings between the Congressional subcommittee and HEW officials, HEW agreed to eliminate the self-sufficiency requirement but to continue to encourage community health centers to seek and utilize outside funds.

HEW's reassurances, however, were only a temporary fix. As Nixon replaced high-level HEW officials with his own appointees, tensions between HEW and Democratic members of Congress increased, leading many to seek a way to protect War on Poverty programs from executive interference. In June 1973, Congress passed a bill extending funding for a number of health programs that the Nixon administration had threatened to defund. The following year, Congress passed a similar bill, this time including separate funding—$215 million for 1976 and $235 million for 1977—for "community health centers." In defining community health centers, the bill also established some of OEO's policies as formal law. Namely, it mandated that all

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[551] Alice Sardell, *The U.S. Experiment in Social Medicine*, 86.
[552] Alice Sardell, *The U.S. Experiment in Social Medicine*, 86.

community health centers have a community-led governing board.[553] Though the bill was pocket-vetoed after Congress recessed, an identical bill became law in 1975, when Congress overrode President Ford's veto.[554]

Thus, in a somewhat ironic twist, the community health center program emerged from a period of political uncertainty more secure than ever. Nixon's second-term attack on War on Poverty programs had generated an intense Congressional backlash, and the program had benefitted from the scuffle. As they had in previous years, community health centers once again profited from their low visibility. Their inclusion in the 1975 bill, for example, generated little opposition. One of the writers of the Senate legislation remembered, "What surprised me was that no one got more excited about it during that time. There wasn't a lot of knocking at the door saying we want to look at it."[555] Because of its low profile, the community health center program was easily able to ride the wave of Democratic backlash. As a result, community health centers, which had previously operated under the more general authorizing language of the Economic Opportunity Act, now had guaranteed funding, somewhat protected from presidential whims.

From Community to Consumers

In many ways, the community health center program appeared to have achieved unprecedented success. Not only was its funding secure, but its commitment to community control now had formal legal backing. But the program had also undergone a substantial transformation. Though it was able to survive the new era of fiscal austerity, Nixon's policies had left an indelible mark upon the centers. By the mid-1970s, the community health center program was very different than what the reformers of the 1960s had initially envisioned.

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[553] Bonnie Lefkowitz, *Community Health Centers*, 298.
[554] Alice Sardell, *The U.S. Experiment in Social Medicine*, 89.
[555] Alice Sardell, *The U.S. Experiment in Social Medicine*, 95.

In stark contrast to the early days of OEO, when funding for new projects had been plentiful, OHA and HEW officials now demanded that community health centers be "lean and mean."[556] Though HEW had backed away from its proposed policy of self-sufficiency, bureaucrats still pressured centers to extract as many dollars from Medicare and Medicaid as they could. Relying on Medicaid and Medicare not only imposed strict constraints on center budgets, it also curtailed their possible activities. With limited federal support, centers were forced to focus only on health activities that would be reimbursable under those plans. For the community health center program, which had adopted a broad view of what constituted a "health activity," this was a major change. As a writer for the activist group Health/PAC noted, Medicare and Medicaid covered a much more limited spectrum of traditional medical services, and they excluded the programs that had made the centers distinctive: "health education, community health, translation, transportation, home visits, social work, and escort services, are not reimbursable." With their range of activities narrowed, community health centers were forced to fit into the more traditional biomedical mold that reformers like Geiger had so explicitly rejected.

As their activities narrowed, so did the health center program's stated goals. Early reformers had envisioned much more than a program that would provide medical services to the poor; rather, they had hoped to use health as a lever for social reform. In his initial meetings with the OEO, for instance, Geiger had presented the community health model as a way to make a broader intervention in the cycle of poverty.[557] In the heady days of the early War on Poverty, such a goal sounded reasonable and achievable. Many of the health centers' initial activities can

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[556] Bonnie Lefkowitz, *Community Health Centers,* 298-99.

[557] H. Jack Geiger, "Contesting Racism and Innovating Community Health Centers: Approaches on Two Continents" in *Comrades in Health: U.S. Health Internationalists, Abroad and at Home,* eds. Anne-Emanuelle Birn and Theodore M. Brown (New Brunswick: Rutgers University Press, 2013), 112.

only be understood in this context. For example, health centers expended enormous resources on professional and paraprofessional training for community residents—a use of resources that would make little sense if the sole goal was to provide medical services. Instead, reformers hoped that, by training these community members, they might prepare them for employment and careers that could eventually help them out of poverty.[558]

Under pressure to reduce their budgets, however, health centers were forced to abandon these visions of broader social reform. Sociologists Hessler and Beavert noted that, in the early 1970s, "[the] ideology of federal government involvement in breaking the cycle of poverty through health center jobs and the prevention of illness began to shift."[559] Instead of using health to eliminate poverty, centers began to focus more narrowly on providing health services to the poor. This change completely reoriented the community health center program, eliminating some of its most "radical" possibilities.[560]

Similarly, the language of community control, long the defining aspect of the community health center program, underwent a subtle but decisive evolution. Nixon's second term had ushered in a new era of political discourse. As Ira Katznelson notes in his book *City Trenches*, political rhetoric at all levels of government underwent a major shift in the 1970s, as the language of "power and powerlessness, internal colonialism, repression, poverty, racial and ethnic discrimination, participatory democracy, and community control" was replaced with "managerial and fiscal matters, […] balancing budgets, bondholder confidence, service cutbacks, wage freezes, municipal employee layoffs, the erosion of the tax base, and making do with

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[558] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 158.

[559] Richard Hessler and Carolyn Beavert, "Citizen Participation in Neighborhood Health Centers for the Poor: The Politics of Reform Organizational Change, 1965-77." *Human Organization* 41, no. 3 (September 1, 1982): 249.

[560] Lekowitz, 202.

less."[561] The language of community control, political empowerment, and authenticity had undergirded the community health center vision. As it began to erode, community health centers adapted to the changing political tides.

While the reformers of the 1960s had spoken of community control, emphasizing the notion of authentic community representation, by the 1970s, health center bureaucrats were beginning to speak increasingly instead of "consumer control." Consumer activism had enjoyed a resurgence in the 1960s and 1970s, driven by what Lizabeth Cohen has dubbed the "third-wave consumer movement."[562] A "broad-based mass political movement" driven primarily by women and African Americans, the consumer movement linked the economic and the political, leveraging its advocates' status as consumers to make new demands on the state.[563] Activists called for marketplace regulation, for example, in order to ensure that the "flourishing mass consumer economy…be safe, democratic, and equitable."[564]

Consumerist rhetoric was not limited to a handful of activists. By the late 1960s, consumer-based language had entered the popular lexicon, imbuing American consumers with a new sense of empowerment. Health care felt the effects as well. In her book *Remaking the American Patient*, the historian Nancy Tomes writes that "medical consumerism" peaked in the late 1960s and early 1970s, giving rise to a new breed of "patient-consumer."[565] These patient-consumers not only urged increased regulations and consumer protections, but also

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[561] Ira Katznelson, *City Trenches: Urban Politics and the Patterning of Class in the United States* (Chicago: University of Chicago Press, 1981), 4.
[562] Lizabeth Cohen, *A Consumers' Republic: The Politics of Mass Consumption in Postwar America* (New York: Vintage Books, 2003), 347.
[563] Lizabeth Cohen, *A Consumers' Republic*, 363.
[564] Lizabeth Cohen, *A Consumers' Republic*, 414.
[565] Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: The University of North Carolina Press, 2016), 285.

fundamentally reconceptualized the doctor/patient relationship by demanding a larger say in their own health care.[566]

As consumerist rhetoric made its way into health care, it was adopted by the bureaucrats operating the community health center program. By the 1973, sociologists at Tufts studying the community health center program noted that “consumer,” “community,” “consumer control,” and “community control,” were often used interchangeably.[567] Despite their similarities, however, “consumer” and “community” carried different connotations. As the journalist Nicholas von Hoffman remarked in 1977, “consumer” was “antisocial,” focusing on individuals rather than on their membership in a larger community.[568] Whereas “community control,” then, suggested a politically empowered community exerting its influence, “consumer control” transformed these communities into atomized consumers expected to make individual demands of their doctors.

The ready substitution of “community” for “consumer” thus signaled a broader sea change. Slowly but surely, the OEO and HEW abandoned the search for an imagined authentic community of the poor. Instead, new notions of consumer control posited the poor as individual consumers of health care services. Community control had been a difficult concept, and even liberal reformers had bristled at relinquishing control to the “community.” Consumer control, in contrast, appeared more palatable. Over the course of the decade, community-led governing boards morphed into “consumer watchdogs” whose presence provided a necessary check on health centers, but whose existence did not radically alter its operations.

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[566] Nancy Tomes, *Remaking the American Patient*, 285.

[567] Peter Kong-Ming New, Richard M. Hessler, and Phyllis Bagwell Cater, “Consumer Control and Public Accountability,” *Anthropological Quarterly* (1973): 196.

[568] Lawrence B. Glickman, *Buying Power: A History of Consumer Activism in America* (Chicago: The University of Chicago Press, 2009), ix.

Community Control in Name Only?

Fiscal austerity and the shift from community to consumer also help explain the situation in Mound Bayou in the mid-1970s. While the move away from the university grantee was likely an inevitable result of the OHA's policy of empowering community governing boards, the messy way in which it occurred seems to have been a consequence of budgetary pressures. The forced merger, despised by most of the Delta Health Center staff, only makes sense when examined within the context of the ongoing political climate. Under pressure to reduce costs and eliminate inefficiencies, combining two health programs that served the same population seemed a natural decision, an easy way to eliminate redundancies.[569] Defending the decision to *Jet* later that year, the head of OHA Dr. Leon Cooper stated that he hoped the merger would reduce "administrative duplication."[570]

Almost immediately after the merger, the health center faced a political crisis when its new OEO grant was promptly vetoed by Mississippi governor William Waller. Waller had always been hostile to the center, but a loophole in the OEO rules had protected the program. While governors did have the ability to veto OEO grants in their states (subject to an override by the head of OEO), the grant for the Delta Health Center had been routed through Tufts and then Stony Brook in Massachusetts and New York respectively. The grants thus fell under those states' purviews, avoiding the reach of the Mississippi governor. With the withdrawal of Stony

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[569] Program analyst Dorothy Mann promised Geiger that, as a "sweetener" for the merger, funding would not be cut for the first year. This promise highlights the ongoing fiscal pressures: the implication, after all, was that, without a merger, the center might otherwise face budget cuts. Mann's promise also seemed to suggest that, in the long term, reductions would eventually be unavoidable: the merger would only stave off these cuts for another year. Jack Geiger, "Report on H. Jack Geiger's Trip to Delta Health Center," January 13, 1972, pg. 8, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[570] "Veto of $5.5 Million in OEO Funds Perils Future Health Care for Town in Miss.," *Jet*, August 3, 1972, pg. 48.

Brook and the rewarding of the grant to the merged community board, the OEO grant became vulnerable to Waller's veto. Waller immediately wielded this power, vetoing the grant on the grounds that the Delta Health Center "did not meet state requirements," "duplicated services already in the area," and was "operating on an invalid license."[571]

Though the head of the OEO, Phillip Sanchez, retained the power to override this veto, Waller's decision prompted a political dilemma. The Nixon administration, engaged in an effort to woo Southern Democrats to the Republican party, was reluctant to confront a prominent Mississippi Democrat.[572] Instead, Sanchez stalled, providing the center with an interim grant while he studied Waller's complaints. On July 29, 1972, Sanchez overrode the veto and reinstated the remainder of the grant. When Waller responded by vetoing the grant again, Sanchez initiated another "careful review" of Waller's objections. After revising the grant to provide for "close monitoring of expenditures," Sanchez overrode the second veto, writing to Waller, "I hope our two offices can work together effectively in the future within our common goal of best serving and assisting the people of the Mound Bayou area."[573] Waller, placated by the revisions, backed off.

But the merger posed other problems as well. Mississippi did not have any state laws that regulated free-standing clinics, so the Delta Health Center had been able to operate mostly free of harassment. The merger with the hospital threatened this balance. Hospitals were subject to state licensure, and the merger meant that the center would be treated as the outpatient clinic

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[571] Board of Directors of the Delta Community Hospital and Health Center, "Memo," July 5, 1972, pg. 1, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[572] Board of Directors of the Delta Community Hospital and Health Center, "Memo," July 5, 1972, pg. 2, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill; "Veto of $5.5 Million in OEO Funds Perils Future Health Care for Town in Miss.," *Jet*, August 3, 1972, pg. 48.

[573] Austin Scott, "OEO Again Overrides Waller Veto on Mississippi Health Center Funds," *The Washington Post and Times Herald*, Sept. 19, 1972, pg. A2.

of the hospital. As Geiger pointed out in a letter to Mann, by merging with the Mound Bayou Hospital, the center made itself more vulnerable to the whims of state government: "The effect of this is to give the state for the first time political leverage over the health center."[574] While the veto issue was eventually resolved, state interference continued to dog the center.

Furthermore, while the political back and forth may have dominated the headlines, the merger also created internal issues that undermined the stability of the center. For example, while the Delta Health Center had always faced difficulty in attracting qualified physicians to work in rural Mississippi, the loss of university affiliation exacerbated the issue. Tufts had offered physicians at the health center faculty appointments at Tufts Medical School, and, without these appointments as incentive, the health center found it difficult to recruit staff.[575] At the same time, rampant discontent within the newly merged center made it difficult to retain existing staff. By the fall of 1972, just months after the merger and the exit of SUNY Stony Brook, one of the center's six physicians had left, and four of the remaining were making plans to follow.[576] As staff left the center, both voluntarily and involuntarily, the quality of medical care began to decline.

The impact of the merger was felt almost immediately. Geiger had worried that the merger, though it purported to put the center in the hands of the community, would spell the end of community control. Critiques of new administration quickly surfaced, seeming to confirm Geiger's fears. Writing under the pseudonym "Sad Nurse," for example, a former employee of the Delta Health Center sent a letter to the *Memphis Commercial Appeal* condemning the new

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[574] Jack Geiger, "Letter to Dorothy Mann," March 13, 1972, pg. 1, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[575] Thomas J. Ward Jr., *Out in the Rural*, 158.

[576] Thomas J. Ward Jr., *Out in the Rural*, 158.

leaders, who she claimed were running the hospital and health center for personal profit and political gain, rather than for the best interests of the community:

> Do you think anyone is surprised then to see Earl Lucas appoint his wife director of nursing or his brother director of personnel? Do you think anyone is surprised to see him use the OEO grant that is supposed to pay for health care for poor people from all over the Delta to pay the whole water bill for Mound Bayou, or to pay for a police force and fire department for this town so he can have a lot of patronage jobs to fill? Do you think anyone is surprised to see Owen Brooks running the whole show, when Owen Brooks was never elected by the poor or the public but was somehow added on to the health council without an election just in time to become chairman of the whole merger?[577]

"Sad Nurse" ended her letter on an ominous note, "I said before that this had to be an unsigned letter. If you even showed it to Lucas or them they might figure out who I was and go after my relatives who are still there. I am sorry if I sound melodramatic but I cannot be foolish and take chances […] There are millions of dollars at stake for those people."[578]

Over the next few years the situation continued to devolve. After the program's $5.5 million budget was reduced to $3.3 million, 130 of the center's 450 employees were laid off.[579] A few years after the "Sad Nurse" letter exposed the problems with the new leadership, Truman White, a citizen of Mound Bayou, echoed these complaints in a letter to Geiger. The situation in the health center, he explained, had deteriorated quickly under the new administration. He reported that the center had become a "tool of the Mound Bayou Political Administration," rather than a community institution. Those who dissented with the political leadership, he claimed, found themselves denied medical service and unable to receive prescribed medications.[580]

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[577] Sad Nurse, "Letter to Mr. A. B. Albritton," July 31, 1972, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[578] Sad Nurse, "Letter to Mr. A. B. Albritton," July 31, 1972, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[579] Thomas J. Ward Jr., *Out in the Rural,* 160.

[580] Truman White, "Letter to Jack Geiger," Dec. 2, 1975, Folder 50, Box 7, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

These allegations thus paint a picture of a health center in swift decline. Over the period of a couple years, the Delta Health Center—once the model community health center—had lost many of the aspects that defined the community health center program of the mid to late 1960s. Not only had the notion of community control been undermined, budget cuts had eroded the very notion of preventative medicine. Describing the change, Herman Johnson, a Mound Bayou alderman, explained,

> We used to be able to make attempts at cleaning up the kind of living conditions that result in serious disease here. We were concerned with water and sanitation, with helping people to build better homes, with creating better living conditions for people. We were battling disease at its source. Now we're back to treating the results of bad environmental conditions that will continue to produce the same health problems in the same people over and over again. We've lost our ability to prevent disease that can be prevented.[581]

Fiscal austerity had taken an undeniable toll. OEO officials had justified the merger using the rhetoric of community control, but, under pressure from the Nixon administration, they had ultimately prioritized "administrative efficiency" over community representation. As budget cuts chipped away at the health center's most innovative programs, the result was community control in name only.

The Delta Health Center was one of the last to be transferred to HEW. By 1974, all community health centers were under the auspices of the department. Former OHA officials, now with no programs left to administer, dispersed. Some accepted positions in HEW, while others chose to work more closely with community health centers in administrative positions.[582] Meanwhile, under HEW, the community health center program entered a period of accelerated

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[581] Joseph Huttie Jr., "New Federalism and the Death of a Dream, in Mound Bayou, Mississippi," *New South* 28, no. 4 (1973): 28.

[582] Interview with Ann Haendel, St. Pete Beach, Florida, June 25, 2016; Phone Interview with Lucia Hatch, July 12, 2016; Interview with Sarah Atkeison, Albuquerque, New Mexico, June 26, 2016; Interview with Dorothy Mann, June 28, 2016, Seattle, Washington.

growth. In 1974, there were 158 community health centers, but by 1980, the program had ballooned to 872. As Bonnie Lefkowitz points out, growth was a survival mechanism for the perpetually imperiled program. By placing centers in more Congressional districts, bureaucrats accrued political support.[583]

By some measures, then, the community health center program was thriving in the mid-1970s. Community governing boards had finally taken control of the centers, and the program was growing at an unprecedented rate even in the midst of political turmoil. These communities, however, presided over health centers that were much more tightly constrained than their predecessors. Fiscal austerity continued to plague the centers. Though the number of centers increased, the appropriations for the program failed to keep pace, and only cuts from older centers sustained the new ones.[584] President Ford continued Nixon's policies of fiscal austerity. Under his administration, HEW instituted a number of measures designed to quantify the centers' productivity. Though generally abhorred by the health centers, these measures "helped show decision makers that they were fiscally responsible," thus giving the program some political protection.[585]

Medical reformers like Geiger had envisioned community councils that identified and worked to solve their communities' most pressing problems. However, as community health centers were forced to conform to a narrow biomedical model, this vision seemed farther away than ever. Writing for the *Health/PAC Bulletin*, health activist Sara Santana lamented,

> In a sense, the system has won its War on Poverty. We have been defused and diffused. Just maintaining what we have takes all our energy; there is not time or resource left to expend on education, housing, organizing. By giving the community some money tied with regulatory strings, the govern-

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[583] Bonnie Lefkowitz, *Community Health Centers*, 298.
[584] Bonnie Lefkowitz, *Community Health Centers*, 298.
[585] Bonnie Lefkowitz, *Community Health Centers*, 298.

> ment has shifted the burden from itself to us. Even as we are slowly strangled by reduced funding, the media and policy makers say that if we do not succeed in hacking out way through the morass of bureaucratic demands to deliver good, inexpensive care to the poorest and sickest within our devastated and impoverished community, it is our fault, proof that community control doesn't work and people can't provide for themselves.[586]

The community health center model had consisted of three major elements—comprehensive health care, community training and employment, and community control. As the program entered its second decade, the demands of a new political climate had systematically undermined all three of these principles. By the mid to late 1970s, the program's prospects looked bleak.

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[586] Sara Santana, "The View from the Community," *Health/PAC Bulletin* 12, 22.

CONCLUSION

The Radical Promise of Community Health

In 1971, Eveline Burns, an economist at the Community Service Society in New York City, confidently noted, "It seems inevitable that within the next two or three years, at latest, something called a health insurance program will be enacted."[587] To twenty-first-century readers, this confidence may sound naive, but, to her contemporaries, Burns' projection likely appeared to be well founded. In the early 1970s, national health insurance was more than just a reformer's pipe dream. Across both parties, there was a widespread belief that the state of health care in the U.S. had reached the breaking point. Even President Nixon, who had earned the support of the AMA in his 1968 election, was sounding the alarm: "Unless action is taken within the next two or three years, we will have a breakdown in the medical system."[588]

National health insurance had been a goal of liberal reformers in the U.S. since the mid-1920s, when the Committee on the Cost of Medical Care (CCMC), an independent group of economists and physicians, began a series of reports on medical care. Over the course of five years, the committee issued 27 reports, detailing escalating health care costs and lamenting the "lack of a system" to organize medical care.[589] Their final report, issued in 1932, was also their most controversial, with the committee recommending a system of voluntary national health insurance that could distribute the costs of medical care more evenly and rationally across the entire American population. These recommendations, however, earned a quick and vehement

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[587] Eveline M. Burns, "Health Insurance: Not if, or when, but what kind?" *American Journal of Public Health* 61, no. 11 (1971): 2164.

[588] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 241.

[589] Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton: Princeton University Press, 2009), 15.

reaction from the AMA, which denounced the proposal as "socialist," "communist," and an "incitement to revolution."[590]

The fierce opposition of organized medicine effectively stymied any talk of national health insurance. When FDR sought to draft a social insurance bill just three years later, his Committee on Economic Security flirted with the idea of incorporating provisions for national health insurance into the Social Security legislation but ultimately scrapped it, deciding "extreme care is necessary to avoid the organized opposition of the medical profession."[591] Similarly, efforts under the Truman administration to amend Social Security to include health insurance were quashed by the AMA, which spent $2.5 million to defeat the plan.[592] Opposed by the well-funded AMA, plans to increase health insurance coverage through federal intervention were not considered politically feasible for decades.

By the late 1960s, after years of deadlock, national health insurance finally seemed imminent. Medicare and Medicaid, which were both passed in 1965, appeared to have opened the door to federal involvement in health care, and skyrocketing medical costs suggested a looming crisis.[593] Between 1960 and 1975, the federal government's spending on health care

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[590] Thomas B. Gore, "A Forgotten Landmark Medical Study from 1932 by the Committee on the Cost of Medical Care," *Proceedings (Baylor University. Medical Center)* 26, no. 2 (2013): 143.

[591] Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton: Princeton University Press, 2009), 17.

[592] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 234.

[593] The sociologist Jill Quadagno has posited that Medicare was able to pass because it was backed by the AFL-CIO, whose strength and organization rivaled that of the AMA. Jill Quadagno, "Why the United States has no National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996," *Journal of Health and Social Behavior* 45 (2004): 32.

increased from $10.8 billion to $27.8 billion.[594] As the situation looked increasingly unsustainable, both liberals and conservatives agreed that immediate action was necessary.

In 1970, Congress took up the question of national health insurance for the first time in twenty years and was immediately flooded by a number of proposals.[595] By the spring of the following year, twenty-two proposals were under review, a few of which quickly emerged as front-runners. Leading the pack of the liberal proposals was a bill introduced by Senator Ted Kennedy, Representative Martha Griffiths, and Representative James Gorman. Dubbed the Kennedy-Griffiths plan, the bill proposed a single-payer program to provide free, universal health insurance. Funded by a combination of tax revenue and a social security payroll tax, the plan would eliminate insurance premiums for medical services. The bill also proposed to create a Health Security Board to control medical costs.[596]

Feeling pressure to compete with Kennedy as the 1972 election loomed, Nixon introduced his own alternative.[597] While the Kennedy-Griffiths bill proposed a single system, Nixon's plan called for a regulated insurance market, relying heavily on health maintenance organizations (HMOs) to help keep medical costs under control. Under this system, employers would be required to provide health insurance to their employees. Individuals who could not afford insurance would be covered by a Family Health Insurance Program (FHIP), which would draw funds from tax revenue to provide basic but minimal benefits.[598]

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[594] John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury Publishing USA, 2009), 239.

[595] Richard D. Lyons, "Senate Panel to Open Hearings on Health Insurance," *The New York Times*, September 22, 1970, pg. 33.

[596] John Dittmer, *The Good Doctors*, 243.

[597] Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*. (New Haven, Connecticut: Yale University Press, 2013), 53.

[598] John Dittmer, *The Good Doctors*, 242.

Even the AMA entered the fray. Sensing a changing tide and believing that some form of national health insurance was likely, the AMA decided it would be wiser to introduce its own bill for consideration than to sit on the sidelines. The AMA plan, known as "Medicredit," recommended a voluntary system that would provide tax credits to those who chose to purchase private insurance. Individuals who paid under $300 per year in taxes would receive free coverage, with other low-income groups receiving subsidies to help with the cost. Unsurprisingly, the AMA plan was the most conservative of the proposals. Unlike most other plans under consideration, Medicredit did not include any mechanism for capping medical costs, leaving the power to set fees firmly in the hands of the medical profession.[599] Despite these limitations, the AMA plan seemed to signal a major political turning point. After all, if even this staunch foe of federal intervention felt compelled to put forward a proposal, national health insurance was surely inevitable.

Confident that national health insurance was imminent, the Medical Committee for Human Rights (MCHR) waded into the national debate. Surveying the proposals, the MCHR concluded that none was satisfactory. In an interview with *Modern Hospital*, the chairman of MCHR, Dr. Quentin Young, stated that, while the Kennedy bill was "far and away the best proposal offered," it did not go far enough. Young criticized the bill's reliance on Social Security, which he deemed "repressive," and maintained that health care should instead be funded by corporate taxation. But the most significant problem, he argued, was the bill's "failure to provide for consumer participation and control of the services at the local level."[600] Kennedy's bill addressed health care access and costs, but it did not attempt to reorient the health care institutions themselves. More fundamental change, the MCHR concluded, was necessary.

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[599] John Dittmer, *The Good Doctors*, 241-242.

[600] George W. Downey, "Medical Rights Committee Plans 'Crusade for Medical Justice,'" *Modern Hospital*, June 1971, Folder 459, Box 40, Walter Lear Collection, Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania.

With these ideas in mind, the MCHR set out to craft its own alternative proposal—one that would incorporate Kennedy bill's provisions for free health care but that would also transform health care institutions. The task of drafting a proposal fell to Dr. Thomas Bodenheimer, a young physician in the MCHR who had published a number of critiques of the existing health care proposals.[601] Bodenheimer's analysis of these proposals was even harsher than Young's. The idea of "national health insurance," he argued, was inherently flawed: "National health insurance, then, is not a massive popular movement toward better health care. It is, rather, a creation of the financially shaky elements of the health power structure. These elements are calling for a well-known American remedy: public subsidy."[602]

If national health insurance merely propped up traditional health care institutions, Bodenheimer called for their overhaul. In the completed document, titled "MCHR Position Paper on National Health Care," Bodenheimer proposed a system that would eliminate for-profit medicine. Under this plan, the federal government would use revenue derived from a wealth tax to fund a medical system that would provide free, comprehensive health care to all Americans. Health care professionals would become salaried government employees, with their education paid for by the state. Health insurance companies would be abolished altogether.[603] Perhaps the most radical recommendation, however, was at the local level, with Bodenheimer suggesting that all health care institutions would be run by community boards staffed by consumers and workers. These community-run institutions would in turn be administered by regional boards, which

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[601] John Dittmer, *The Good Doctors*, 244.
[602] Thomas S. Bodenheimer, "The Hoax of National Health Insurance," *American Journal of Public Health* 62, no. 10 (1972): 1324.
[603] John Dittmer, *The Good Doctors*, 244.

would also consist of a mix of community members and workers. Bodenheimer laid out a vision of a new kind of health care system—a "community-worker controlled national health service."[604]

Thus, just a few years after the OEO had begun its community health center program, Bodenheimer was proposing a radical move, the exponential expansion of the community health concept. While community health had served as the basis for limited programs serving carefully circumscribed communities, it had never been enacted on a wide scale within the U.S. From Walsh McDermott on the Navajo reservation to Kurt Deuschle in Kentucky, to Jack Geiger in Mississippi, medical reformers had primarily understood community health as a way to help disadvantaged communities. When the OEO had resisted the conflation of community health with "poor people's medicine" and toyed with broadening the use of community health by serving all residents in a designated area, these attempts had met fierce Congressional resistance.[605] Community health, it seemed, was only for the poor. Bodenheimer's plan, however, proposed to expand community health care to all populations, taking the lessons of the community health centers and applying them across the country. "Every doctor in the country should be working in these kinds of institutions," Bodenheimer declared, "This will distribute the doctors to where they should be, and organize medical care in a rational kind of way."[606]

Among MCHR members, Bodenheimer's proposal was met by enthusiastic praise. The late 1960s and early 1970s had marked a major transition in the organization, which had moved increasingly leftward since the mid-1960s.[607] In its earlier years, the MCHR had been a decentralized organization that supported the activities of its local chapters. As the organization had

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[604] John Dittmer, *The Good Doctors*, 245.
[605] Daniel I. Zwick, "Some Accomplishments and Findings of Neighborhood Health Centers," *The Milbank Memorial Fund Quarterly* 50, no. 4 (1972): 410.
[606] John Dittmer, *The Good Doctors*, 245.
[607] Lily M. Hoffman, *The Politics of Knowledge: Activist Movements in Medicine and Planning* (Albany: State University of New York Press, 1989), 72.

moved leftward, however, it struggled to address critiques that its focus on health professionals was too “elitist.” As health radicals called for a more egalitarian organization, the MCHR responded by expanding its constituency, shifting from a reform-minded professional organization to a “mass organization incorporating all strata of health workers and of consumers as well.”[608] At the same time, the MCHR centralized its national office, turning its focus to legislative advocacy and political mobilization, rather than the community health centers, free clinics, and other independent projects that the previous generation of MCHR professionals had championed. In order to sustain this centralized organization, MCHR leadership needed a unifying cause, and Bodenheimer’s proposal seemed well-suited for the role. At the 1971 MCHR convention, the organization almost unanimously approved the proposal, making it the central platform of their national campaign, the National Health Crusade.[609] For a brief, heady moment, it seemed to many that the radical promise of community health care could form the core of a national health system.

However, while the MCHR health care proposal was packed with principles, it was light on specifics. In fact, Bodenheimer himself admitted that the proposal had taken just a day to write.[610] The adopted proposal listed goals such as “end profit-making in health care,” “[provide] complete and preventative health care with no charges for health services,” and “[administer] medical centers locally through representatives of patients and health workers,” but details on

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[608] Rhonda Kotelchuk and Howard Levy, “The Medical Committee for Human Rights: A Case Study in the Self-Liquidation of the New Left,” in *Race, Politics, and Culture: Critical Essays on the Radicalism of the 1960’s*, ed. Adolph L. Reed (Westport, CT: Greenwood Press, 1986), 164.

[609] Rhonda Kotelchuk and Howard Levy, “The Medical Committee for Human Rights: A Case Study in the Self-Liquidation of the New Left,” in *Race, Politics, and Culture: Critical Essays on the Radicalism of the 1960’s*, ed. Adolph L. Reed (Westport, CT: Greenwood Press, 1986), 167.

[610] John Dittmer, *The Good Doctors*, 244.

how these goals could be implemented were less forthcoming.[611] Community control, for example, was a principle that community health centers had been struggling to realize even on a very limited scale, and the MCHR proposal did not explain how the often-ambiguous term could be expanded to a much wider population. As a critic from the Chicago Health Research Group pointed out, the proposal struggled to define the term, failing to distinguish between "workers' control" and "consumer control."[612] Beyond the terminology, the proposal also raised a number of logistical issues. When an interviewer for *Modern Hospital* asked how regional community boards would be able to allocate resources, Dr. Felicia Hance of the MCHR sidestepped the question, remarking, "It's very interesting problem, and it's not a problem that one formula can solve."[613]

Even more detrimental than these pragmatic concerns were the political ones. The MCHR proposal had garnered media attention, but there was never any real chance of such a plan passing Congress. Indeed, the plan was never introduced in Congress, and organizations like the AMA refused to even debate it. Years later, Bodenheimer believed he had made a tactical error in pushing for the MCHR plan at the expense of the Kennedy bill: "We made this horrible mistake of saying, 'The Kennedy bill is a piece of crap.' We should have supported the Kennedy bill."[614]

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[611] The Medical Committee for Human Rights, "A Monograph from MCHR's National Health Plan Task Force," Folder 464, Box 40, Walter Lear Collection, Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania.

[612] Vincent K. Pollard, "Workers' Control and Consumer Control," Folder 459, Box 40, Walter Lear Collection, Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania.

[613] George W. Downey, "Medical Rights Committee Plans 'Crusade for Medical Justice,'" *Modern Hospital*, June 1971, Folder 459, Box 40, Walter Lear Collection, Barbara Bates Center for the Study of the History of Nursing, University of Pennsylvania.

[614] John Dittmer, *The Good Doctors*, 246.

Regardless, the window for any kind of reform soon closed. With 22 proposals before Congress, none was able to win enough support to gain significant traction. As John Dittmer has pointed out, opponents of national health insurance were able to rely on the "tried-and-true tactics of divide and conquer" to ensure that no bill gained the requisite backing. Finally, the Vietnam War overshadowed the national health care debate in the 1972 presidential election.[615]

The issue of national health care briefly resurfaced in 1974, but prospects for major reform were rapidly slipping away. While the 1971 debates had focused on increasing health care coverage, by 1974 the conversation had shifted to cost containment.[616] Kennedy still championed national health insurance as the best way to reduce health care costs, but the moral urgency behind the movement had faded. And once again, the issue of national health care was eclipsed by other events—this time the growing Watergate scandal.[617] Despite reformers' optimism at the beginning of the decade, a national health care plan seemed as distant as ever.

The failure of the MCHR's National Health Crusade hastened the decline of the organization. MCHR leadership had relied on the campaign for national health care to revitalize the organization, and, without this shared mission, the MCHR's constituency had little left to bind it together. Former members Rhonda Kotelchuk and Howard Levy later charged that "instead of asking what the MCHR could do for a national health care plan, the MCHR instead asked what a national health-care plan could do for it."[618] Over the next few years, MCHR

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[615] John Dittmer, *The Good Doctors*, 247.

[616] Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven, Connecticut: Yale University Press, 2013), 59.

[617] Paul Starr, *Remedy and Reaction*, 59.

[618] Rhonda Kotelchuk and Howard Levy, "The Medical Committee for Human Rights: A Case Study in the Self-Liquidation of the New Left," in *Race, Politics, and Culture: Critical Essays on the Radicalism of the 1960's*, ed. Adolph L. Reed (Westport, CT: Greenwood Press, 1986), 168.

membership dwindled rapidly. By 1975, an article in *American Medical* stated that the organization was merely "a shadow of its former self."[619]

The Fate of Community Health

The memory of the 1960s was fading in medical schools as well. Community medicine departments had begun to dissolve in the early 1970s, after the OEO backed away from its earlier policy of university sponsorship and began to give grants directly to community boards. By the end of the decade, the remaining departments had "considerably weakened" as their "missions" had become "diffuse."[620] Dr. Robert Tranquada, who had served as the chairman of the department of community medicine at USC and had helped to found the Watts Health Center, reported in the early 1980s, "The department of community medicine that I founded is now almost entirely devoid of anything that might be called community medicine."[621] Instead, he explained, community medicine had been supplanted by pure epidemiology, losing in the process any connection or commitment to communities that received care.

As community health departments declined, they were replaced by "primary care," a growing movement pioneered by international health organizations like the World Health Organization (WHO).[622] A much broader term that encompassed "family medicine," general internal medicine, and general pediatrics, primary care largely lacked the specific political

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[619] John Dittmer, *The Good Doctors*, 257, 260.
[620] Jo Ivey Boufford, "Medical Education and Training for Community Oriented Primary Care," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings*, eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 167.
[621] Robert Tranquada, "Discussants," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings*, ed. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 190.
[622] For a history of the origins of the primary care movement, see Marcos Cueto, "The Origins of Primary Health Care and Selective Primary Health Care," *American Journal of Public Health* 94, no. 11 (2004): 1864-1874.

connotations of "community medicine."[623] Indeed, primary care had more in common with the comprehensive care movement of the 1950s than with the community medicine of the 1960s. Both, in fact, were reactions to the increasing specialization of medical education and practice.[624]

In the early 1980s, the Division of Health Care Services at the Institute of Medicine convened a conference to discuss how "community medicine" and "primary care" could be integrated into an "action-oriented," "population-based" program.[625] In planning for the conference, conveners settled on the term "community-oriented primary care" (COPC), the term first coined by Dr. Sidney Kark, to unite "community orientation," "demographic or epidemiological investigation," "personal medical services," "environmental intervention," "community organization," and "health education."[626] Attendees, however, struggled to create a synthesis, and the conference ultimately revealed major cleavages in a supposedly united front. Conference participants, for example, could not agree on the definition of "community." Dr. Kurt Deuschle, then chairman of Mount Sinai's Department of Community Medicine, argued for a broad understanding of community health, describing a recent project in which Mount Sinai had partnered with the Gulf Western Americas Corporation to provide health care for the firm's employees in the Dominican Republic.[627] Drs. Joseph Abramson and Sidney Kark adopted a

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[623] Fitzhugh Mullan, "Preface," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings,* eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), vi.
[624] Fitzhugh Mullan, "Preface," vi.
[625] Jo Ivey Boufford, "Medical Education and Training for Community Oriented Primary Care," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings,* eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 167.
[626] Eileen Connor, "Overview and Summary," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings,* eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 2.
[627] Kurt W. Deuschle, "Community Oriented Primary Care: Lessons Learned in the Past Three Decades," in *Community Oriented Primary Care: New Directions for Health Services Delivery:*

similarly expansive definition. "The 'community' in COPC," they wrote, "could be […] a 'true' community, in the sociological sense; a defined neighborhood; workers in a defined factory or company, students in a defined school, etc.; people registered as potential users of a physicians' groups practice, [or] users of a defined service."[628] Geiger, on the other hand, strongly objected, "With the possible exception of a 'defined neighborhood,' these aggregates are not communities, as either health workers or the members of communities themselves understand that term."[629] "Community," he argued, was not a "catch-all" term.[630]

The conference proceedings shed light on the mixed legacy of the community health center program just a decade later. From one perspective, certain elements of the health center program—its focus on comprehensive health services, for example—had "diffuse[d] into the mainstream."[631] But at the same time, by the 1980s, the political implications that had animated the community health centers of the 1960s were rapidly falling out of favor among even reform-minded health care professionals. "Community control," for instance, had dropped from the discourse altogether.

As the MCHR declined and the memory of the radical possibilities of community health faded from the medical profession's collective consciousness, individual health centers struggled to adjust to the changing landscape. As Chapter 5 has described, fiscal austerity in the 1970s

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Conference Proceedings, eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 12-14.

[628] Joseph H. Abramson and Sidney L. Kark, "Community Oriented Primary Care: Meaning and Scope," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings*, eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 24.

[629] H. Jack Geiger, "The Meaning of Primary Care in the American Context," in *Community Oriented Primary Care: New Directions for Health Services Delivery: Conference Proceedings*, eds. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 64.

[630] H. Jack Geiger, "The Meaning of Primary Care in the American Context," 64.

[631] H. Jack Geiger, "The Meaning of Primary Care in the American Context," 87.

took its toll on the community health center program. Though the centers were able to survive, the community health care model suffered as its more radical innovations became casualties of tightened budgets.

Like many in the early 1970s, the medical reformers behind the community health centers had assumed that national health insurance was imminent. As they built community health centers, reformers looked anxiously toward the future: what role would community health centers play in the future landscape of health care? Some even worried that national health insurance might have a detrimental effect on the centers. If universal health insurance opened up new options for the poor, would they continue to visit their local community centers? In a 1971 letter about the Delta Health Center, John Hatch remarked, "It is not certain that all persons presently getting care at the Center and the Hospital will choose to continue this arrangement when a choice is possible." Would community health centers be competitive enough to survive in a new era of consumer choice?[632]

The political reality, however, was markedly different. As dreams of national health insurance faded, the trends that had begun under Nixon continued even after he left office. Carter's administration offered a "breathing spell" for the centers, but rapid inflation thwarted any major revival of the program.[633] Later, Reagan's election ushered in an era of conservatism and more cutbacks for the health centers, forcing them to develop new strategies for survival.[634]

Some health centers adapted better than others. The Watts Health Center, for example, was able to weather the cutbacks relatively successfully. In 1971, at the same time that Nixon

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[632] John Hatch, "Letter to William Crockett," December 1971, Folder 46, Box 6, Delta Health Center Records, Southern Historical Collection, University of North Carolina, Chapel Hill.

[633] Bonnie Lefkowitz, *Community Health Centers: A Movement and the People Who Made It Happen* (New Brunswick: Rutgers University Press, 2007), 16.

[634] Bonnie Lefkowitz, *Community Health Centers*, 17-20.

was advocating for HMOs on the national level, Governor Reagan increased support for HMOs in California through changes to the state's Medi-Cal program.[635] Shortly afterward, the Watts Health Center took advantage of these changes, ditching its fee-for-service model and forming an HMO.[636] The new model proved more profitable for the center, and, by the 1980s, it was able to invest the funds from its HMO premiums into various "community empowerment and development" projects, including mobile clinics, substance abuse programs, HIV counseling, and adult day care.[637]

The Mile Square Center in Chicago, in contrast, encountered significant difficulties. In 1973, after being transferred to HEW and no longer constrained by the OEO's strict definition of "community," the center expanded its service area from the "Mile Square" neighborhood to the entire metropolitan area. The move was an ambitious one to increase its revenue base, but it also marked a major change for the center. Serving an increased patient population, the center was no longer able to provide the same comprehensive services that it had under OEO, and it was forced to scale back its transportation programs, job training programs, and home visits. Home visits, for example, dropped from 30,624 in 1971 to just 5,466 in 1978. As the expanded base put more pressure on the center, it was also forced to change its basic model of care. Like most OEO community health centers, the Mile Square center had employed a system of "family health care teams" that included physicians, as well as nurses, social workers, and other "ancillary

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[635] For more on Reagan and Medi-Cal, see Jenna Loyd, *Health Rights Are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: The University of Minnesota Press, 2014), 212-220.
[636] Jenna Loyd, *Health Rights Are Civil Rights: peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: The University of Minnesota Press, 2014), 203.
[637] Karen Robinson-Jacobs, "State Regulators to Carve Up 'Holistic' Community Group," *Los Angeles Times*, September 3, 2001.

personnel." After the expansion, however, this model proved unwieldy, and the center switched to a more traditional system of primary care providers.[638]

The cutbacks, however, could not save the center. In 1989, after years of financial struggle, the center declared bankruptcy and closed.[639] Two years later, it reopened as a "joint venture" between the University of Illinois-Chicago and the city health department.[640] The Mile Square Health Center continued to persist, but it had lost much of what had once made it unique—its commitment to the community, its comprehensive services, and its team-based model of medical care.

The Columbia Point center also struggled. Though it had been the first OEO-funded community health center, Columbia Point had never quite taken off in the way other centers had. In part, the center was hampered by its location. Though Geiger and Gibson had initially seen the public housing project as an ideal epidemiological demonstration, its isolation later proved to be more of a detriment than an advantage. Health center staff had found it difficult to organize the public housing residents, and the center never had the same level of community involvement as many of the other centers had achieved. Jack Geiger later admitted, "I was much less invested in Columbia Point; never thought of it as an instrument of social change—the label that had been

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[638] Jean Ruffin, "Mile Square Health Center in Chicago, Illinois" in *Health Services Integration: Lessons for the 1980s, Volume III* (Washington, D.C.: Institute of Medicine, National Academy of Science, 1982), 104.

[639] John W. Fountain, "Closing of Health Center Called "Tragedy for West Side's Poor," *Chicago Tribune*, October 8, 1989; Jean Latz Griffin, "Politics Keeping Clinic Closed," *Chicago Tribune*, Sept 28, 1990.

[640] James Krone Jr., "Who's Afraid of Paula Wolff?: The UIC Chancellor Flap: What Was That All About?" *Chicago Reader*, May 16, 1991.

applied to the center in Mississippi."[641] The center managed to survive the move to HEW, but it struggled with persistent financial difficulties until 1984, when it went into receivership.[642]

Desperate to keep their federal grant, the Columbia Point center's leaders contacted Dan Driscoll, the head of the Neponset health center a few miles away, and asked him to take over. Driscoll agreed, and the two organizations merged to form Harbor Health Services. In some ways, the two centers seemed to be an unlikely pair. While Columbia Point served a Hispanic and black population, Neponset residents were mostly Irish working class.[643] But Driscoll was already well acquainted with the center, having studied the relationship between Tufts and Columbia Point during graduate school.[644] The merger saved the health center, though it came at a cost. The two organizations were supposed to form an equal partnership, but, twenty years later, Columbia Point residents remained underrepresented on the community board. In 2002, Driscoll, still head of Harbor Health Services, reported, "There's still a big brother-little brother dynamic, and only about 25 percent of the board is minority when it ought to be 60 or 70 percent."[645]

The Delta Health Center followed yet another path. Like the other community health centers, Delta faced cutbacks in the 1970s, but political troubles compounded these financial struggles.[646] Having merged with the Mound Bayou Hospital at the behest of the OEO, the center found itself torn between two groups—the Mound Bayou "elite," led by Mayor Earl Lucas, and the first generation of health center staff, many of whom still remained loyal to Jack Geiger and John Hatch. Indeed, L.C. Dorsey, a former sharecropper who had worked with Hatch

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[641] Bonnie Lefkowitz, *Community Health Centers*, 71.
[642] Bonnie Lefkowitz, *Community Health Centers*, 71.
[643] Bonnie Lefkowitz, *Community Health Centers*, 72.
[644] Bonnie Lefkowitz, *Community Health Centers*, 63.
[645] Bonnie Lefkowitz, *Community Health Centers*, 72.
[646] Thomas J. Ward Jr., *Out in the Rural: A Mississippi Health Center and its War on Poverty* (New York: Oxford University Press, 2017), 158-59.

on the health center's farm co-op before leaving for graduate school, found it impossible to find a job at the center when she returned. "They were not hiring anybody who were identified as part of the Geiger/Hatch group," she recalled, "So we came back with papers in hand and found ourselves totally unemployed."[647]

With the center in turmoil, Medicare and Medicaid, rather than relieving the financial burden, exacerbated it. Delta residents who qualified for these federal programs now had choices to make, as hospitals that had once rejected them now welcomed their business. Finding it hard to compete for patients, the Mound Bayou Hospital shuttered in 1983, leaving the health center in a precarious position. A year later, HEW threatened to revoke the center's grant unless it overhauled its leadership and produced a new board.[648]

The order from HEW sent the center leadership into a frenzy. Over the next three years, six different directors attempted to head the project, with each one falling victim to internal politics. Finally, in 1988, a new board was created, this time with L.C. Dorsey as executive director. Dorsey's professional qualifications and long-standing ties to the Delta Health Center seemed to make her an ideal candidate. Since her failed attempt to get a job at the health center in the mid-1970s, Dorsey had pursued a career in health, earning a doctorate in social work at Howard University before working at the Memphis Health Center.[649]

During her tenure, Dorsey stabilized and revitalized the center. Over the next several years, the center regained its financial footing and expanded its services.[650] But her return to the center also hinted at the long-term impact of the Delta Health Center. Though the center in the

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[647] Thomas J. Ward Jr., *Out in the Rural*, 159.

[648] Thomas J. Ward Jr., *Out in the Rural*, 162.

[649] "Dorsey Selected as New Director of Health Center," *Delta Democrat Times*, Folder 260, Box 12, John Hatch Papers, Southern Historical Collection, University of North Carolina, Chapel Hill.

[650] Thomas J. Ward Jr., *Out in the Rural*, 162.

eighties barely resembled the OEO-funded center that Geiger and Gibson had founded over two decades earlier, Dorsey’s career was a testament to the long legacies of the community health experiments of the 1960s. Geiger would later note that he believed the community training to have been one of the most important elements of the health center program. In a 1992 interview, he recalled, “Directly or indirectly, this has made a difference in terms of the educational aspirations and educational achievement of people. For the longer term, that may be one of the most important consequences of this intervention.”[651]

The community health centers had pioneered a radical model of health care in the late 1960s. Decades later, the results were mixed. Many centers continued to survive and even thrive, but they did so within a new set of parameters. In order to adapt to financial and political pressures, the centers conformed to a “market model.” Geiger had envisioned centers that would act as an “instrument of social change,” but, by the 1990s, he noted regretfully that most had become “federally funded Medicaid mills urged to be lean, mean and competitive—as if anybody were competing to take care of these populations.”[652]

A New Consensus: Community Health Centers as Safety Nets

In his 2000 presidential campaign, George W. Bush, preaching a philosophy of “compassionate conservatism,” made community health centers an important part of his platform. Then, in his first year as president, Bush presented a plan to establish 1,200 new sites (many health centers operated multiple sites) and double the number of patients served by the program.[653] Indeed, even as the budgets for other social programs were cut to address increasing deficits,

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[651] Thomas J. Ward Jr., *Out in the Rural*, 164.

[652] Jack Geiger, “Community Health Centers: Health Care as an Instrument of Social Change” in *Reforming Medicine: Lessons of the Last Quarter Century*, eds. Victor W. Sidel and Ruth Sidel (New York: Pantheon, 1984); Thomas J. Ward Jr., *Out in the Rural*, 169.

[653] Bonnie Lefkowitz, *Community Health Centers*, 23.

funding for community health centers managed to increase, doubling over the course of Bush's eight years. By 2008, 1,297 sites had been added, though the number of patients fell shy of the initial goal, increasing by sixty percent. According to federal officials at the time, the expansion of community health centers under Bush was the "largest since the program's origins in President Lyndon Johnson's war on poverty."[654]

In 2010, the Affordable Care Act, or Obamacare, gave community health centers another significant boost. Expanding Medicaid eligibility meant that a greater proportion of the centers' patient population was covered, which in turn increased the centers' revenue. The law also created a "health center trust fund" to provide grants to help cover the cost of services that were not specifically covered by Medicare and Medicaid.[655] The Mile Square Center, for example, received $250,000 to support behavioral health services. With these funds, the center was able to hire psychiatric staff, including a substance abuse and addiction counselor.[656]

The impact of these benefits was felt unequally. After a 2012 Supreme Court decision made Medicaid expansion optional for states, many Republican governors opted out of the program.[657] According to a 2017 report by the Kaiser Family Foundation, health centers in these "non-expansion" states found it more difficult to draw revenue from Medicaid and were forced

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[654] Kevin Sack, "Community Health Clinics Increased During Bush Years, *New York Times,* December 26, 2008.

[655] Julia Paradise et al., *Community Health Centers: Recent Growth and the Role of the ACA* (Menlo Park, California: The Henry J. Kaiser Family Foundation, 2017).

[656] Sharon Parmet, "UI Health's Mile Square Health Center Receives Funding for Behavioral Health," August 13, 2014.

[657] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012). As of January 1, 2017, nineteen states had opted out of Medicaid expansion. Julia Paradise et al., *Community Health Centers: Recent Growth and the Role of the ACA* (Menlo Park, California: The Henry J. Kaiser Family Foundation, 2017); Adam Liptak, "Supreme Court Upholds Health Care Law, 5-4, in Victory for Obama," *New York Times,* June 28, 2012.

to rely more heavily on federal grant money. In contrast, health centers in "expansion states" had "larger-scale operations" and "greater service capacity."[658]

Despite these inconsistencies, the ACA had a major impact on community health centers. Over the course of just two years, the number of patients served by the centers increased by 2.6 million, or ten percent.[659] Together, Bush's expansion and ACA represented a major shift for the community health center program. Between 2000 and 2015, the number of health centers in the U.S. increased by two-thirds, and the number of patients served more than doubled. By 2015, 1,278 federally funded community health centers were serving an estimated 24.3 million patients.[660]

In a political environment of increasing polarization, community health centers appeared to be an anomaly. Despite the vitriolic nature of the health care debate, community health centers were able to win the support of both Republicans and Democrats. At a time when any health legislation met political resistance, the bipartisan appeal of the health center program sheds light on an emerging consensus. As the radical promises of community health faded, community health centers had become more politically palatable. Bush, for example, praised the program as a "safety net" that could provide "access to healthcare in a practical way."[661] For these Republicans, community health centers were an obvious solution. They helped the most vulnerable members of society without altering the rest of the health care system. Some critics, in fact, accused Bush of bolstering the community health centers to stave off broader reform.[662]

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[658] Julia Paradise et al., *Community Health Centers: Recent Growth and the Role of the ACA* (Menlo Park, California: The Henry J. Kaiser Family Foundation, 2017).

[659] Julia Paradise et al., *Community Health Centers*.

[660] Peter Shin, et al., *Community Health Centers: A 2013 Profile and Prospects as ACA Implementation Proceeds* (Menlo Park, California: The Henry J. Kaiser Family Foundation, 2017); Julia Paradise et al., *Community Health Centers*.

[661] Edwin Chen and Vicki Kemper, "Bush Highlights Community Health Centers in 2005 Plan," *Los Angeles Times*, May 26, 2004.

[662] Bonnie Lefkowitz, *Community Health Centers*, 23.

The ACA increased coverage, but it did not fundamentally change American health care institutions. Obamacare was a far cry from Thomas Bodenheimer's dream of community health care for all; instead, it most closely resembled Nixon's plan of a regulated insurance market. Despite their growth, community health centers remained part of the American safety net, rather than an integral part of mainstream health care.

The politics of the 2000s thus shed light on a fundamental paradox that had troubled the community health center program since its inception. Community health had its roots in efforts to serve marginal populations that were excluded from mainstream medicine; however, many of its most prominent advocates had also touted their projects as demonstrations and hoped their models could be applied more broadly. Struggling to resist classification as "poor people's medicine," community health centers never quite reconciled these dual roles. The success of the community health center program, then, was inextricably connected with the failure of its radical promise.

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LIST OF ACRONYMS

ACRONYM	TERM
ACA	Affordable Care Act
ADC	Aid to Dependent Children
AFL-CIO	American Federation of Labor and Congress of Industrial Organizations
AMA	American Medical Association
BIA	Bureau of Indian Affairs
CCMC	Committee on the Cost of Medical Care
CEA	Council of Economic Advisers
CHW	Community Health Worker
COFO	Council of Federated Organizations
COPC	Community-oriented Primary Care
CORE	Congress of Racial Equality
FHIP	Family Health Insurance Program
GAO	Government Accountability Office
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
HRUM	Health Revolutionary Unit Movement
MCCR	Medical Committee for Civil Rights
MCHR	Medical Committee for Human Rights
NAACP	National Association for the Advancement of Colored People
NMA	National Medical Association
OEO	Office of Economic Opportunity
OHA	Office of Health Affairs
PAC	Policy Advisory Center
PHS	Public Health Service
SCLC	Southern Christian Leadership Conference
SCMHSC	South Central Multipurpose Health Services Center
SHO	Student Health Organizations
SHP	Summer Health Project

ACRONYM	TERM
SMC	Student Medical Conference
SNCC	Student Nonviolent Coordinating Committee
USPHS	United States Public Health Service
WHO	World Health Organization