

## **First ever Nation-wide Summit of Community Health Center Clinicians meets in Washington D.C. on eve of election to call for Health care Justice and Equity**

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Community Health Center clinicians from across the country converged on Washington, D.C. on October 23 and 24, 2008 in a historic meeting kicked off by 10 Surgeons General recommending strategies for communicating the urgency of the childhood obesity epidemic and wrapped up by Dr. Jack Geiger, one of the physicians who founded the first community clinic in rural Mississippi in the 1960's.

The conference was sponsored by fourteen organizations, including NACHC, the Association of Clinicians for the Underserved, the Migrant Clinicians Network, and all the regional networks of health center doctors and dentists (including the Western Clinicians Network, which includes California). Clinicians and Medical Students from across the country were energized by some of the most influential healthcare leaders in the country.

“Over the years, we have noticed that fewer clinicians are attending meetings like the annual NACHC meeting, the national farmworker health conference and the regional migrant farmworker conferences,” said Karen Mountain, CEO of the Migrant Clinicians Network. “The organizers decided to hold a national conference for clinicians.” The goal is to energize them in their one-on-one work with patients and re-engage them in the larger political, legal, and public health struggles that complement this everyday work.

The day before the conference began, several participants met with congressional staffers to discuss the issues of health care right and called for universal access to health care.

One chance interaction with a resident of Washington D.C. emphasizes the effect of lack of access to health care. When Dr. Neil Calman, a family physician and CEO of the institute for Family Health in New York, arrived in Washington, he noted that the cab driver who took him from Union Station to the conference hotel had a large, untreated mass in his mouth. Like many good clinic doctors, he made the diagnosis of a dental abscess, called in a prescription for antibiotics, and directed him to follow up at a local community clinic.

On Friday night, the conference participants held a vigil at West Senate Park. “In two weeks, this country will have elected a new president,” said Dr. Calman at the vigil. “No matter who wins, the axis of opposition, the insurance companies, the pharmaceutical companies, organized medicine, will resist true reform. After the election, more than ever, health center clinicians must become active, on behalf of our patients, to fight for health care equity.”

Powerpoint presentations and some streaming video/audio from the conference will be available at a website created for this conference, at [www.allclinicians.org](http://www.allclinicians.org).

The National Summit of Clinicians for Healthcare Justice was very different from any conference I have attended before. I feel privileged to have attended. I hope this summary imparts some of the passion I gained from this event to both clinicians *and* staff in community

health centers who did not attend, and serve as catalyst for achieving a vision of health equity and justice in our health care system. Here are some highlights.

### Surgeons General Panel on Childhood Obesity

Media coverage of the historic panel of 10 current and past Surgeons General was extensive as they each shared some pearls on how to energize the nation to reverse the epidemic of childhood obesity. Here are some of the remarks made by each speaker.

- Current Acting US Surgeon General Rear Admiral Steven Galson, MD MPH reviewed current data on the childhood obesity epidemic, noting particularly the lowered self-esteem and chronic emotional stress that accompanies the physical consequences of obesity.
- Recent Acting US Surgeon General Kenneth Moritsugu, MD MPH stressed that the obesity epidemic touches everyone, and that clinicians must “connect the dots” with other agencies to make changes occur: the chamber of commerce/business community, the schools, the faith community are examples.
- 17<sup>th</sup> US Surgeon General Richard Carmona, MD MPH noted that funding to address the obesity epidemic is competing with many other pressing national issues. For example, a growing percentage of our teens are in such poor physical condition that they cannot qualify for military service, reducing the pool of potential soldiers. This makes childhood obesity a national security issue.
- Dr. David Satcher, 16<sup>th</sup> U.S. Surgeon General, suggested the need to partner with businesses and insurance companies to give incentives for healthy lifestyles.
- Past Acting US Surgeon General Audrey Manley, MD MPH stressed the role of the “Health Care Home” as an important location for primary prevention of childhood obesity.
- 14<sup>th</sup> US Surgeon General Antonia Novello, MD MPH, DrPH stressed the need to change the financing system to allow longer preventive care visits with children, to more effectively conduct prevention activities in the health care setting.
- C. Everett Koop, MD ScD, 13<sup>th</sup> US Surgeon General, stressed the need to develop collaborative relationships with the press to wage a more successful public health/media campaign.

Only three states in the U.S. have an office of state Surgeon General. All three of the current office holders attended, and offered highlights on their local efforts towards reducing childhood obesity:

- Michigan Surgeon General Kimberlydawn Wisdom, MD MPH noted that Michigan has added BMI measurement to their state vaccine registry, to gather real-time comprehensive data on childhood obesity. She also highlighted a pilot program where multi-disciplinary teams focus on a multisectoral approach to increased activity and improved nutrition in communities with particularly high rates of childhood obesity.
- Florida Surgeon General Ana Viamonte Ros, MD MPH highlighted the Florida Governor’s Council on Physical Fitness, which spearheaded a visionary law requiring 150 minute of physical education in the schools (Compared to California’s unenforced

100 minutes per week), and a program to bring fresh local produce into all Florida schools.

- Arkansas Surgeon General Joseph Thompson, MD MPH stated that he believed that obesity and its complications are contributing to rising health care costs, and stressed that prevention is cost effective, in the big picture.

Dr. Koop concluded the panel with a call to action: “Life accords no greater responsibility and privilege than helping the next generation.”

### Discussions of Human Rights and the Right to Health Care

Is health care a right, a privilege or a commodity? What does it mean to call for “Health Care Justice?” What is the difference between Health Equity and addressing Health Disparities?

Physicians, philosophers and lawyers addressed these key questions throughout the conference.

Immigration rights lawyer Sarah Paoletti gave the audience a logical framework for understanding how the fundamental human rights of immigrants are being violated by current U.S. government policy. In particular, she showed how the term “illegal” cannot be applied wholesale to undocumented immigrants. For example, a wife of a US citizen may not have documents, but has a legal right to remain in the United States while her petition for residency is considered. The same goes for immigrants applying for political asylum: they have a legal right to remain in the United States until they are granted asylum or until all appeals are exhausted. Only undocumented individuals with an active deportation order have no legal right to remain. Nonetheless, undocumented immigrants legally applying for asylum, in many parts of the country, are detained and incarcerated in state prisons, or are held at detention centers where they receive substandard medical care, putting their lives at risk. Sadly, many have died in these conditions.

Dr. Edward Zuroweste, MD, Chief Medical Officer of the Migrant Clinicians Network, notes that there are two broad categories of rights:

- Conditional rights. These include those granted to citizens (such as the right to vote), or to permanent residents (such as the right to work).
- Unconditional rights. These should be accorded to every human on earth, include the right to live and the right to be free from torture. Because lack of basic health care puts peoples lives at risk, basic health care is a part of the right to live.

Ethicist and philosopher Kenneth Goodman noted that a right to health care is not an individual right, like the right to free speech or the right to be free from search and seizure. Health care requires outside entities (a clinician and health care system) to provide the service. While individual clinicians have some duty to provide care for their patients, they do not have a duty to provide unlimited care to all, regardless of ability to pay. Thus, health care is a right that is granted by society. What is the basis of this right? Dr. Goodman states the societal right of vulnerable populations to health care can be made based on the ethical principles of consistency and impartiality. It is unethical for society to provide inferior health care to vulnerable population, *because* inferior care causes harm to vulnerable individuals, in an unequal way.

What is the ethical obligation of clinicians in community health centers? How do we respond to attempts by the government to deny health care to undocumented individuals?

Is it ethical to break the law if it will save a life? Is it OK for a doctor to exceed the speed limit to race to the hospital to allow you to resuscitate a critically ill newborn (yes, by California law)? Is it ethical to participate in court ordered execution by injection (no, by decision from CMA and constituent specialist organizations)?

Is it ethical to deny basic health care to anyone in our country, because of documentation status, whether because of government policy or private policy (private hospitals, for example)? Dr. Zuroweste stressed that many major groups representing physicians (including AAFP, AAP, NACHC) have stated that civil disobedience is ethically justified if needed to provide health care to vulnerable populations in spite of government regulations. He urged the audience to be sure health center clinicians across the country are aware of this.

Several speakers noted that universal health coverage is necessary, but not sufficient to insure health equity, justice and access. Adding universal health insurance coverage that has the effect of moving patients out of health centers is likely to *harm* their health status instead of help it. This is because the health care system outside community clinics and large closed HMO models (like Kaiser) is increasingly fragmented and overspecialized.

Washington D.C. pediatrician Gloria Wilder tackled the issue of health justice by looking at five pillars of social justice:

- Quality health care
- Quality education
- Environmental justice (quality housing, clean water, free of violence, etc.)
- Economic Opportunity
- Civil and Criminal Legal Justice

“Insecurity in any one of these areas hurts the others,” she said. Thus, if we are truly interested in the health of the community, we must believe in and work towards all of them. “We must team up with lawyers, teachers, law enforcement, housing authorities and other government agencies,” to have a coordinated approach to achieving health justice and equity through social justice.

#### Role of health care providers in reducing violence

Dr. John Rich, a Massachusetts General Hospital-trained Internist gave a powerful and insightful presentation illustrating the underlying causes of inner city violence, and offering a model for healing.

The main societal paradigms for handling violent individuals perpetuate further violence and an incarceration rate that is the highest per capita of any country in the world. One paradigm is that perpetrators of violence are “*bad*” and need to be punished: locked up and away from society. A

second is that violent individuals are “*sick*,” they have personality disorders that are not their fault; they need to be treated (by mental health professionals). Neither approach has much success changing the individual’s future propensity to violence, or changing the underlying causes in society.

Dr. Rich advocates for a third paradigm, that individuals committing acts of violence have been injured and need healing. He points out that they have witnessed many acts of violence, beginning at a young age, causing emotional injury and post-traumatic stress disorder, leading to emotional numbing and, eventually, commission of acts of violence. Healing can only occur through a joint effort of the injured person and the health care system.

“I believe that human society can evolve to be non-violent and socially just,” he says. The key is to create an environment of “sanctuary, where the wounds caused by sustained exposure to trauma can be healed.” Using peer outreach workers who have been healed themselves to work with emotionally and physically traumatized individuals has been a promising approach.

#### Lack of Health Equity: Underlying causes of health disparities

Dr. Adewale Troutman drew from an impressive host of resources ranging from the World Health Organization Convening on the Social Determinants of Health, to the landmark PBS series on health inequities to examine the underlying causes of health disparities. While well-recognized factors such as education, occupation, and income account for some of the disparities in health outcome, discrimination and stress associated with race/ethnicity, poor housing, and powerlessness (both personal and political) have now been proven to play critical roles.

The responsibility of clinicians is to take the best care of their patients that they can, to address the disparities, but also to look “upstream,”

Dr. Troutman illustrates with a parable: “Two men are fishing on a fast flowing river, and they start to see small children coming down the river, drowning. One man jumps into the river to save the children, but the other starts running along the bank, upstream. ‘Where are you going?’ demanded the man in the river as he pulled out a child. ‘Help me pull them out!’ he yelled.

The man on the shore answered, ‘You pull them out, I’m going to see who’s throwing the children in the river and stop them.’ ”

Dr. Troutman recommended physicians work with their communities to organize them to create their own community-based statement of rights, to ask local politicians to sign this document, and hold them accountable when they are not meeting the needs set out in this statement of rights. (He recommends the National Association of County and City Health Officials as a good resource for ideas and documents for these efforts [www.naccho.org](http://www.naccho.org).)

#### How far have we come? How far do we have to go?

Dr. Jack Geiger was one of the closing speakers at the conference. He made his name in the 1940s for starting a student strike which led to desegregation of University of Chicago hospitals

and later to admission of the first African Americans as medical students to the University of Chicago in over 20 years. He later became a physician himself, working in the first Community Health Center in rural Mississippi, and co-founding the organizations Physicians for Social Responsibility and Physicians for Human Rights, both of which have won Nobel peace prizes.

He recalled writing prescriptions for food for starving children at his clinic. The prescriptions were filled at local stores and the bill sent to the health center, charged against the pharmacy budget. When state officials and the office of economic opportunity got wind of this, they met with the doctors to take them to task. The government acquiesced when Dr. Geiger said, "All the major medical authorities agree that the treatment of choice for starvation is food."

Reflecting on his long career observing the health care system, Dr. Geiger noted that most major changes to the health care system occur in short bursts lasting just a few years, often associated with a war. He thinks that we may be on the verge of a burst of change, but that is up to the new generation of clinicians to be the activists for positive change.

### The Amazing Non-collapsing US Healthcare System

Columbia University School of Public Health professor Lawrence Brown followed up on the theme of what it will take for a transformation of the US health care system, noting the fundamental tension between affordability and universality. If we achieve universal care with the present wasteful, hyper-specialized health care system, the costs will increase dramatically, which won't be tolerated by government budgets or business. If we try to reign in the cost of care, the "Coalition of the Unwilling" will fight to prevent reform: the insurance industry, organized medicine, and pharmaceutical/medical technology companies.

Other American values are also barriers to health reform:

- deep distrust in big government,
- the American belief that the job of the government is to fill health care gaps of the private system, rather than to ensure universally accessible basic health care
- health care as a fringe benefit of employment instead of a fundamental human need

Dr. Brown notes that the window of opportunity for changing the national health care system opens only every 10-20 years, and if there is ideological discord, no reform will occur (this is what happened in 1993 in the US, in the first year of the Clinton administration). He stresses that we should strive for as much ideological unity for the solution before the next window of opportunity is open, lest we lose the opportunity (as happened in California in 2007-2008).

### A Call to Action for Clinicians and Staff in Community Health Centers

Executive Directors and Medical Directors of Community Clinics should invest time and energy in energizing their clinicians and staff to work for the health of our communities in a broader way, keeping in mind these principles:

- Give your patients respect and caring; give them a medical home. Part of that respect and caring is to continuously improve the systems of providing care.

- Take care of yourself, so you can keep taking care of patients.
- Remember why you went to work at a community health center: you are not just a technician, but an agent for change.
- Don't substitute charity for justice -- we need both.
- Make linkages in your community to empower your patients, personally and politically. It is especially important to cultivate relationships with local media.
- Balance your work downstream saving lives one at a time, with work upstream, working to prevent the underlying causes of health inequity.
- Understand the ethical and moral basis for these three declarations, so that you can passionately proclaim them: Health care is a fundamental human right! Health equity for all! Health justice for all!
- Finally, community health centers are growing rapidly in the United States, and provide the most cost-effective, just, equitable, caring health care anywhere in the United States. As private practices close and community health centers grow in community after community, our country is finding that we are the best model for health care. We need to proudly advance this model, and BE the change we want to SEE.