

impartial evaluation of new arms projects costing and wasting billions. To be exact, twenty-three billion dollars have been spent on certain missile projects that were abandoned in the past decade, according to recent studies.

Qualified critics attribute this enormous waste to the rush to develop new weapons in response to Soviet threats that later were conceded *never to have existed*—the “bomber gap,” the “missile gap,” et cetera. This destructive waste of our resources will not stop until we elect men to represent us who possess a nobler brand of patriotism and who will not be subverted by fear or personal gain. Patriotism without genuine spiritual roots bends easily.

On Going to Jail Again

They are all there, waiting, my dark or pale
Sisters flung from the poverty jungles,
Whose children have the wrong name and address.

Once you take off your shoes, and clean latrines,
They forgive your college education,
Forgive your teaching three generations
And never, No! Not once saving one child
of theirs from Murder, Incorporated.

“You a peacenik? They call you terrible
Names. We think you love kids, all kids. Here’s mine.”
From her worn, colored, photo young eyes gaze:
Hoping, wanting, seeking. They kindle our eyes.

I am a coward. I dare not count,
Dare not add up the total of children
Robbed, robbed of their Mothers I meet in jail.

Worse! From early childhood I am trained, skilled
To recognize the human potential:
That nineteen-year-old black imp, mocking, gay,
Asked for my wedding ring—“a souvenir”—
And grabbed my special orange, saved for her,
Dancing away before I could give it.

This was because I had caught her playing
Both chess and Scrabble at once
And made her promise somehow to survive
Jail’s stupefactions, and somehow go on
To magnify black genius that is hers.

Someone like Jeannie, Queen of Hell’s Angels,
May sulk there in muscle-bound fury:
Each day, in beautiful calligraphy,
Jeannie wrote out my scrawls and petitions
And got them past the prison censor’s glare.
I should have memorized her poem for us—
green, green savannahs, rhythmic, sunny winds!
“To prevent conspiracy in future”
This song she gave me was confiscated.
I said, “You are a motorized gypsy!”
While I rub your back, I’ll enlist your aid.
Ride, ride to our next demonstration.
Set your cycles between us and the cops!”
Next month in L.A. Hell’s Angels rode in
And saved our peaceable assembly there.

ISOBEL CERNEY

Medical Problems of the Ghetto

by Joan E. Thomas, M.D.

AS A GENERAL PRACTITIONER in a slum in Louisville, Kentucky, I have had interesting and tragic experiences with the special problems of the poor.

My office is between two poverty areas in which about **forty percent** of the families, or more than **eight thousand** persons, live on annual family incomes of less than **three thousand dollars** a year. Nearly all my patients are poor. Nearly all are black. They are of all ages. About one-fourth of them are children.

They have the same illnesses as the more affluent for the most part, but in some respects their medical problems are different. For example, about ten percent are treated for gonorrhea. I probably have more than my share of drifters and other irresponsibles, but I have been astonished at the frequency of this disease in stable, respectable persons. While I live in fear of penicillin reactions, many of them treat the whole subject with less concern than they do the common cold.

Most members of my patient population have characteristics that would be considered mentally unhealthy in some other groups. For example, nearly all are pathologically sensitive and suspicious in their perception of the thoughts and feelings of others. Obviously, knowing what “whitey” is thinking has survival value. **That excess which we call paranoid** handicaps them in dealing with white society and is at least one root of black separatism, but can anybody honestly say that our social climate has improved to the point that correction of this trait is practical?

The diagnosis and treatment of psychiatric, and, indeed, all, health problems is handicapped by poor communication. Many of my patients have a hard time with words, a vague sense of time, and bizarre ideas of anatomy, physiology, and causation. Apparently the “strain” is no mere euphemism for gonorrhea, but is sincerely attributed to the effects of heavy lifting. One woman told me she had been overtreated for “low blood” (anemia) at a hospital, with the result that she had acquired “high blood” (hypertension). Patients with surgical scars frequently cannot tell what organ was removed or why. Even for a current illness, many are unable to give the details of timing, quality, and progression of symptoms that are essential to **intelligent** diagnosis. By the time that one young woman with acute gonorrhea complained that her womb was falling out, I was so weary of trying to make medical sense from nonsense histories that I failed to recognize her schizophrenia until the Mental Health Clinic got in touch with me.

If this is the quality of information coming my way, I wonder what goes back to the patient. How can patients who eat irregularly and ignore appointments be trusted with a potentially lethal drug like insulin, that requires measurement and timing? How can patients who share plumbing with other families effectively perform warm soaks or exercises that are beyond many middle-class patients? The poor frequently require more instruction time, more followups, and longer treatment periods than middle-class patients.

I suspect malnutrition is commonplace. I have many cases of anemia, poor healing, and infections, possibly related to protein deficiencies. Blood analysis of similar populations has demonstrated such deficiencies, and I do know that many of my people subsist largely on potatoes, macaroni, and bread. What can my instructions or medicines do for a nearly blind, toothless, illiterate seventy-year-old woman who lives on a pension of one hundred dollars a month, of which sixty dollars go for rent?

Recommendations of medical school faculties or lawyers for diagnosis and treatment sometimes seem irrelevant. Most of my patients expect even the most subtle problems to be managed by an off-the-cuff diagnosis and a "penicillium" shot. They fail to report for followup; they frequently go to some other doctor or General Hospital if my office is closed and then back to me when next they have a cold or some other discomfort entirely apart from their serious medical problems. The duplication of efforts and confusion of treatments increase expense and decrease effectiveness.

Many cannot afford the X-rays and tests required for scientific medicine. Only about twenty-eight per cent of my patients have private hospitalization insurance or Medicare. They are my rich patients. They are eligible for hospitalization and specialist referrals and I hope can afford the expenses of ordinary care.

About forty percent of my patients have no hospitalization or medical insurance at all. Their incomes are above the Medicaid level but are not steady enough or in the right field to include insurance in the pay package. They range from the family of four trying to make ends meet on thirty-five hundred dollars a year to the young cat with genuine lizard shoes and a fat roll of twenty-dollar bills, but none of them can afford current hospital rates and few of them can scrape up the two hundred dollars or more required as a deposit for uninsured admissions. For people like these, the only recourse in serious or complicated illness is the clinic.

Many people who badly need service would prefer to die in a corner rather than go to a public clinic. At General Hospital, physical facilities are crowded, shabby, hard to sit on, even dirty. Overworked personnel are unable or unwilling to answer questions or arrange assistance. Appointments are not scheduled, so that even sick people have to wait for hours. Even the reduced fees of clinics may be formidable

to patients who have no financial assistance from insurance or Medicaid.

Moreover, if I think the patient needs specialized General Hospital services, all I can do for him is to suggest that he go to a certain clinic; I have no way of arranging that he will actually be seen there. If he does not already have a hospital card, he has to be seen in the emergency room and take his chances of persuading a tired, harassed house officer that he is sick enough to bother with. Under such conditions acute fracture or hemorrhage is well handled; a possible heart attack or cancer is likely to be sent home with some pills. The medical school likes to sneer at general practitioners, but I feel that if they really cared about the quality of community medical practice they would permit private physicians to make specific referrals and be informed of the results.

The reason given for the poor performance of the clinics is lack of money. Up to a point this is true, but the large amounts of additional money from Medicaid and Medicare for clinic fees were used not to improve services but to reduce local government support. For example, the city-county share of the Louisville General Hospital budget has shrunk from eighty-three percent to fifty per cent. I wonder how many other programs designed to help the poor result in hiring clerks and exchanging papers and money but no visible benefit to the client.

About thirty-three percent of my patients are on Medicaid. These are the poorest. In Kentucky, the state will pay on their behalf for specifically listed services in a doctor's office, certain drugs, certain hospital expenses, and extended care services. The patient pays nothing; that I think is a mistake, since he then has no incentive to limit his demands to the necessary or to invest his own effort in therapy.

For some services, payments equal private fees; for others, especially doctors' services in hospitals, they are far less. The list of covered items is arbitrary and omits many services that I consider important, such as penicillin injections and children's immunizations, but covers such exotics as total removal of a lung or internal repair of a heart. The drug list contains such duplications as four tetracyclines, four narcotics, and three oral penicillins, but no eye drops for glaucoma, no mood elevators for depression, no pediatric preparations for anemia or vomiting, nothing for local vaginal infections or ringworm. Payment to the doctor for a hospitalized patient covers three to five days of care, even if the patient requires weeks or months in the hospital.

In short, the frustrations of the Medicaid program are such that most specialists are cool to referrals from a doctor who cannot balance the impositions with a suitable quota of middle-class patients. So it is back to the clinics for these people as soon as they require more than routine care.

The converse of the fact that the poor cannot afford to pay for more than the most minimal services is that doc-

tors in poor areas cannot afford to perform more than the minimum. Both government and private payment programs limit their support to the "usual and customary" fees in the locality. In a poor area, this level is set by what patients with tiny incomes and no insurance can afford—that is far less than among the affluent. So who is to pay for the services I perform for nothing or at half price?

Historically, the slum doctor has managed by seeing a tremendous number of patients, offering a lick and a promise to each. Money can be made this way, but the quality is such that most doctors find it neither professionally nor personally satisfying. Except for a federally supported Neighborhood Health Center and myself, no new doctors have entered the poorest areas of Louisville for years. This is more serious than it would be in more affluent areas, because poor people frequently cannot afford carfare or are afraid to go to office buildings or hospitals for services. Even in lower-middle-class sections, a doctor may see **two hundred** to **three hundred** patients a week; several of the younger doctors have left or plan to leave for specialist training, not because they are so interested in the specialty but to reduce their patient load. So far, all the publicity given Medicaid payments has not enticed doctors into the ghetto.

It is hard to quantify the deficit of doctors in a limited area because of lack of information on movements of patients into or out of the area, rates of utilization of services, and proportions of hospitalized or chronically ill patients. I believe, however (after allowing for populations probably served by the Neighborhood Health Center and General Hospital), that about **ninety-nine thousand** persons in the poorest areas of Louisville are served by about thirty physicians. This means a ratio of **thirty-three hundred** patients per doctor. The national ratio of patients per doctor involved in patient care is 715:1; the Kentucky ratio is 1020:1; the Neighborhood Health Center 900:1.

The problems surrounding the training, distribution, duties, and organization of doctors are beyond the scope of this article, but I think it is apparent that improvement of the health care of the poor is tremendously more difficult than political rhetoric suggests. Not only is it foolish to make promises and appropriations without regard to the supply of services, but it is necessary to recognize that substandard socioeconomic conditions cause unusual illness, hinder effective treatment, and obstruct the delivery of quality service.

Change is in the wind for private and public health programs, but let us study and plan these changes carefully. We need to experiment with efforts to improve the effectiveness and reduce the waste of health services at all social levels before we can unconditionally back or blame any single program.

Getting Rid of Some of the Fat

By Rothwell Bishop

IT WOULD NOT BE a bad idea if we could boil down the Society a little and get some of the fat off it. We are adrift, I think.

Too many of us have forgotten that the center of the Society is Christ, so much so that you can attend meeting sometimes in England for months and never hear his name mentioned.

Several unhappy consequences follow. If Christ is not your man for all seasons, who is? It is too easy, propped by the affection of the group to which you belong, to think that you live the good life with no more assistance than that.

Frankly, I doubt whether you ever reach the full potential of good that is in you, if Christ means almost nothing. Do not ask me why this should be so. I do not know. The divine alchemy of love is beyond my comprehension, but not, thank God, my apprehension, and I feel (with two thousand years of evidence to support the view) that the Cross did make some change in the relationship between God and man that would not have and could not have happened otherwise. Friends seldom mention the Cross.

We quote George Fox's phrase, "Walk cheerfully over the earth" with a great deal of self-satisfaction, thinking that the capacity to remain calm in the face of difficulties is all but the supreme good and forgetting that George Fox walked cheerfully over the earth only because he took seriously the one request in the Lord's Prayer that few of us really mean: "Thy will be done."

Few of us are prepared to submit ourselves wholeheartedly, because we are afraid of taking the consequences, which are not always painful. Instead, too many of us tend to follow Pelagius, who was, as I recollect, the only Briton to be numbered among the early Church fathers and was, alas, a heretic. Not only that, but he was a dangerous heretic, since he propagated the beguiling notion that it is possible to live the good life merely by the exercise of one's own will.

Those who have a social conscience find a home in the Society, and it does seem very often that if we produce good works we must be living under God's guidance. Sometimes I doubt it. We are so very sure of ourselves.

Do not think that I despair of the Society—far from it. There will always be a remnant to whom Christ is more important than anyone else, and though they may not be the weightiest of Friends, they will always be the more influential.