

Appraisal of Health Care Delivery in a Free Clinic

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IN RECENT YEARS there has been an upsurge in the delivery of health services by non-traditional methods, ranging in scope from comprehensive services to services for special problems; for example, drugs and unwanted pregnancy. These methods have been used by OEO- and HEW-funded neighborhood health centers as well as a significant number of "free clinics" (1-3). The activities of some of these clinics were recently reviewed (4).

We describe in detail our experience in an unusual free clinic in Galveston, Tex., during its first 2 years of operation, the implica-

tions derived from that experience, and their application to other nontraditional types of health care delivery.

Background of Operation

St. Vincent's House, a neighborhood center, was opened in 1958. The surrounding area, which is almost exclusively occupied by blacks, is characterized by both underemployment and unemployment. There are two low-income housing projects within 5 blocks of the center and two more within 15 blocks. Another project, 14 blocks away, is separated from the center by the downtown area; it is within 6 blocks of the University of Texas Medical Branch. Significant numbers of nonproject, multifamily residences are situated within the neighborhood. As is typical of such communities, prostitution and drug traffic abound, chiefly in the few blocks immediately adjacent to St. Vincent's House.

In response to community needs, St. Vincent's House developed a recreation program for children, teenagers, and young adults and a preschool program for the children of neighborhood residents. Funding has been and continues to be through private

sources and the local United Fund.

The center is supervised by two co-directors, one black and one white, and policy is set by a board that draws its membership both from the larger community and from the indigenous population.

In October 1969 a local black group, called the Community Operated Opportunities Program (COOP), asked the department of preventive medicine and community health, University of Texas Medical Branch, to sponsor and supervise a health clinic at St. Vincent's House. Although a number of health facilities are available in Galveston, we elected to open the clinic to provide a portal of entry into these systems (described later), particularly for persons who had never availed themselves of the existing resources; to provide direct free services, with no eligibility requirements, as feasible to the area; and to maximally utilize nurses in providing these services. We envisioned an opportunity to develop the clinic as a vehicle for teaching and research in community medicine. The clinic did not receive any funds from sources mentioned previously.

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At the time we opened the clinic, COOP was approved as a project for 15 Volunteers in Service to America (VISTA). Included in the group was a registered nurse who became the clinic nurse. Subsequent VISTA cycles also included one or more nurses, who continued to work at the clinic. Professional volunteers, including nurses, physicians, and a speech therapist, participated on a part-time basis throughout the 2-year period.

General supplies were obtained through the cooperation of this department. The medicines used were physicians' samples, which are typically used in free clinics (4). The local city and county health departments provided material for immunizations. The State health department supplied equipment and medications for diagnosis and treatment of venereal disease but did not supply materials for gonorrhea cultures.

We devised standards for well-person care including medical history, blood pressure recording, vision screening, immunization, a Papanicolaou smear for cervical cancer detection, and hematocrit and urinalysis tests, and treatment protocols for syphilis and gonorrhea, upper respiratory illness, and minor injuries. The medical director, an internist,

was always available and was consulted daily. The clinic was open all day Monday through Friday and also Saturday afternoons. An occasional clinic visit occurred on Sunday, but Sunday visits were unusual. Because staff was available, we elected to remain open during a wide time-span to permit patients to come at their convenience. Additional time during clinic hours was spent in home visits.

As indicated, Galveston has several referral sources including the university's outpatient department and emergency room, a children and youth project in the department of pediatrics, a family planning program, a cervical cancer detection program in the department of obstetrics and gynecology, and well-child clinics run by the city health department. Referrals were made to these services as indicated and sometimes were received from them. The family planning program and the children and youth project operated satellite clinics 4 blocks from St. Vincent's House. Although the patients, particularly those with venereal diseases, were distributed throughout Galveston, 39 percent of the patients came from a 5-block area around St. Vincent's House that included both project and nonproject

housing. Another 39 percent resided within a radius of 6 to 20 blocks of St. Vincent's House. The remainder were scattered throughout the city and the county.

Results

During the first 2 years of clinic operation, 1,300 patients made 1,910 initial visits that required 1,836 followup visits. The distribution of these 1,300 patients by age, race, and sex is given in table 1.

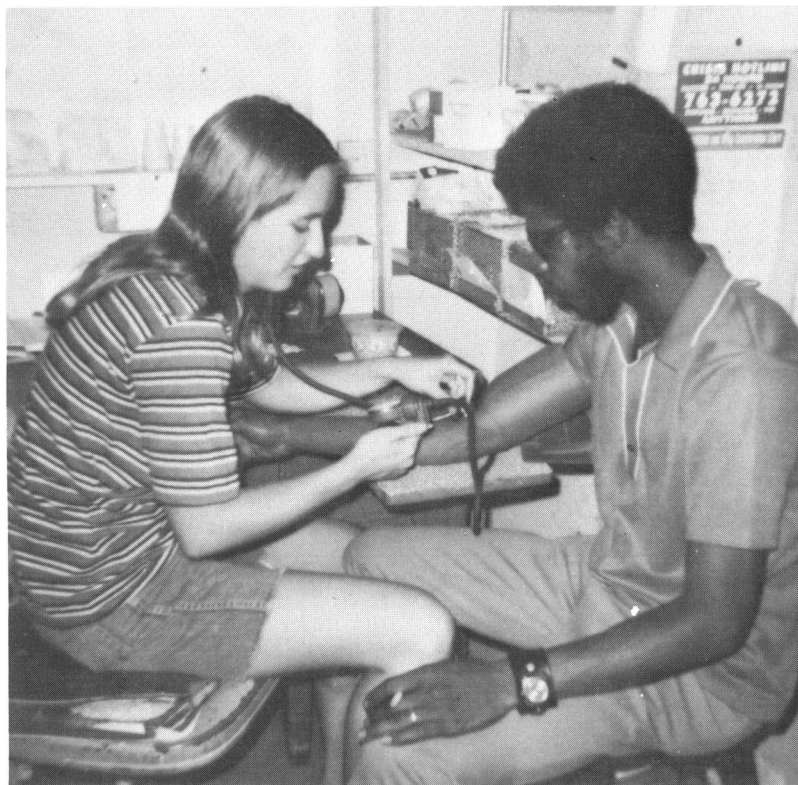
Of the total number of patients, 629 or 48.4 percent were 16 to 30 years old, although all age groups were represented. There were 701 or 53.9 percent males and 599 or 46.1 percent females. (The relatively small percentage of females and children probably resulted because the family planning clinic and the children and youth project were operated nearby.) The three major ethnic groups were comprised of 1,048 or 80.6 percent blacks, 192 or 14.8 percent whites, and 40 or 4.6 percent Chicanos.

In the 1,910 initial visits, two or more conditions were found in 68 patients. Analysis of the diagnostic categories by age, race, and sex is presented in tables 2 and 3.

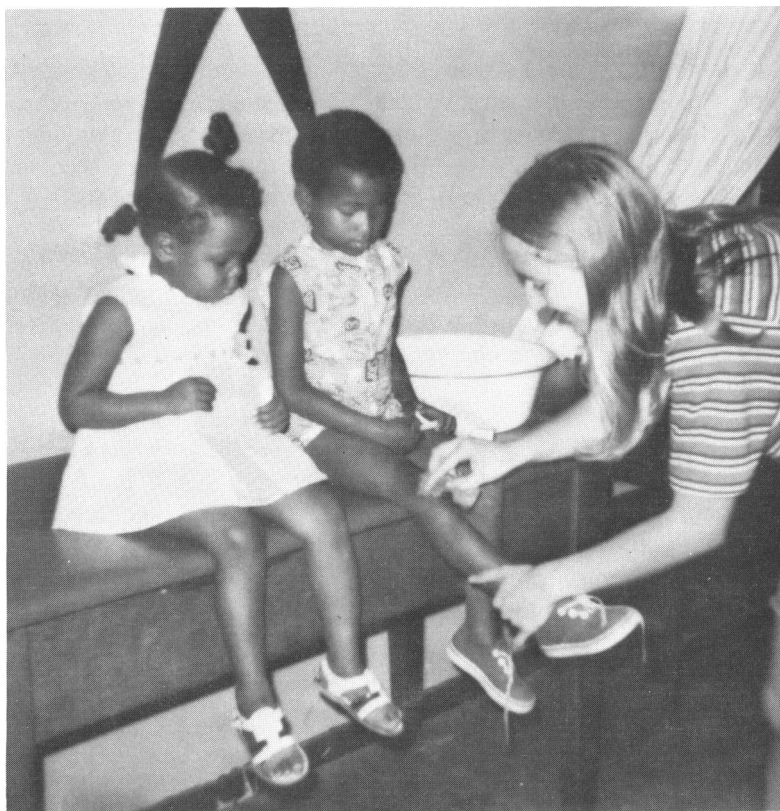
The number of patients with one or more illnesses is shown

Table 1. Distribution of patients by age, sex, and racial or ethnic group, St. Vincent's House clinic, Galveston, Tex., October 1969–October 1971

Age group (years)	Black		White		Chicano		Total	
	Male	Female	Male	Female	Male	Female	Number	Percent
Unknown.....	4	5	0	2	0	1	12	0.9
0-5.....	62	53	4	1	1	8	129	9.9
6-10.....	44	47	5	1	5	3	105	8.1
11-15.....	34	34	2	7	1	2	80	6.2
16-20.....	102	103	35	27	7	7	281	21.6
21-30.....	162	107	45	23	4	7	348	26.8
31-40.....	60	52	10	3	0	3	128	9.8
41-50.....	49	43	12	3	2	3	112	8.6
Over 50.....	40	47	7	5	4	2	105	8.1
Total.....	557	491	120	72	24	36	1,300	100.0



Nurse records a young man's blood pressure. Hypertension is a serious health problem for many of the clinic's patients.



Preschool children are treated for minor cuts and scratches at the clinic

Table 2. Classification of patients' conditions in the venereal disease-related categories, St. Vincent's House clinic, Galveston, Tex., October 1969–October 1971

Category	Age group (years)						Sex		Ethnic group			Total
	11–15	16–20	21–30	31–40	41–50	Over 50	Male	Female	Black	White	Chicano	
Well visit for VDRL test for syphilis..	7	73	56	8	12	4	74	86	105	49	6	160
VD contact.....	3	23	24	4	1	0	21	36	40	12	5	57
VDRL reactive.....	0	17	24	9	6	2	38	20	51	5	2	58
Gonorrhea suspect.....	9	131	223	53	16	1	366	67	351	70	12	433
VDRL reactive and gonorrhea.....	1	11	8	1	3	0	18	6	23	1	0	24

Table 3. Classification of patients' conditions in nonvenereal disease categories, St. Vincent's House clinic, Galveston, Tex., October 1969–October 1971

Category	Un-known	Age group (years)								Sex		Ethnic group			Total
		0–5	6–10	11–15	16–20	21–30	31–40	41–50	Over 50	Male	Female	Black	White	Chicano	
Well.....	4	83	68	37	35	36	22	21	12	154	164	267	33	18	318
Upper respiratory infection.....	3	20	16	9	20	38	23	23	23	70	105	157	12	6	175
Minor trauma or minor surgery.....	0	16	21	19	21	33	22	16	12	98	62	148	9	3	160
Dermatological.....	0	13	9	6	9	13	7	5	16	43	35	66	8	4	78
Gastrointestinal.....	0	9	2	1	11	14	7	13	17	43	31	63	7	4	74
Dental.....	0	4	6	7	9	18	7	5	14	25	45	67	3	0	70
Ear and eye.....	0	8	4	3	6	7	4	10	9	25	26	49	1	1	51
Obstetrical-gynecologic.....	1	0	0	4	9	13	9	9	1	0	46	37	5	4	46
Genitourinary.....	0	0	0	2	8	10	6	6	6	17	21	34	3	1	38
Hypertension.....	1	0	0	0	0	1	6	9	15	15	17	32	0	0	32
Other.....	2	14	5	7	21	35	37	43	39	87	11	184	11	8	203

in table 4. As can be seen, 336 people, or 25.8 percent, visited the clinic because of two or more separate illnesses.

The general disposition of patient visits is shown in table 5. As is evident, the majority of patients were treated at St. Vincent's House. The high figure is partially due to the large number of illnesses related to venereal disease.

Specific Category of Visits

Well visits. We were visited 318 times by 304 persons, 47 percent of whom were children under 11 years old. Checkups were done during well-child visits, immunizations were given, and general examinations of adults were made. Papanicolaou smears, tine tests for tuberculosis, and VDRL tests for syphilis were

done as indicated. Three of the 304 persons were referred to the university's family planning program, and 96 were seen at the clinic on followup visits.

Venereal disease. As mentioned, VD-connected illnesses composed the largest single category of visits, accounting for 38 percent of the total 1,910 initial visits. There were 160 visits by 144 patients for a VDRL test for syphilis. All these patients were well; that is, the VDRL test for syphilis was nonreactive. VDRL analyses were made for 97 checkups, 28 premarital tests, 14 school tests, 12 tests requested by a halfway house for alcoholics, and nine tests required for employment. Followup was needed after 151 visits; nine needed no followup.

A total of 57 visits were made

by 54 people who had been referred because of a history of VD contact—29 for syphilis and 28 for gonorrhea. The serologic test results in this group were nonreactive on the initial visit. Eighteen persons with a history of syphilitic contact and 27 with a history of gonorrheal contact were treated. Twelve patients required no treatment or refused therapy. For six there was no followup visit, but the remainder were seen again.

Fifty-eight visits by 48 people were for syphilis without gonorrhea. Forty-nine such illnesses of 48 patients were treated at St. Vincent's House; in one instance the patient, on a subsequent visit, was referred to the university's outpatient department. For eight patients no treatment was required because their titers con-

Table 4. Frequency of patients' illness, St Vincent's House clinic, Galveston, Tex., October 1969–October 1971

Number of separate illnesses	Number of patients	Percent of total
1.....	964	74.2
2.....	202	15.5
3.....	64	4.9
4.....	37	2.8
5 or more.....	33	2.5
Total.....	1,300	99.9

tinued to fall below a previous VDRL determination. No follow-up of 12 visits was required because the patients were referred to St. Vincent's House for treatment only. The other 46 illnesses required at least one followup visit.

There was no venereal disease clinic in Galveston during the period studied. One or more VD investigators was available intermittently, however, for contact tracing of syphilis patients only.

The largest category in VD-related illnesses was suspected gonorrhea, with 433 illnesses of 306 people. As expected, the disease was much more evident in males: 366 as compared with only 67 females. Males having a history of urethral discharge with or without dysuria were treated as were females with a symptomatic history of the disease or a history of contact with affected males. All VDRL tests for syphilis were nonreactive.

Treatment for 430 illnesses was administered at St. Vincent's House; three patients were treated and referred to another of the university's projects. Gonorrhea was treated with 1.5 gms. of Benemid followed by 2.4 million units of penicillin for males and 4.8 million units for females. (Apparently the patients' treatment failed.) Most patients with

gonorrhea (347) were seen again one or more times (they were not reinfected).

Eighteen persons had both gonorrhea and syphilis. Fifteen had only one initial visit for such an illness, while one person was treated two times, one three times, and one four times. The total number of such combined illnesses was 24. All such patients were treated at St. Vincent's House, and all were seen one or more times in followup.

Upper respiratory illness. A total of 175 illnesses in this category occurred in 141 patients. No treatment was required during 12 visits; during 152, the patients were treated at the clinic. Four patients were referred to the university's emergency room for suspected complications of their illnesses. Seven patients treated at St. Vincent's House were referred to the university's outpatient department for a second diagnosis. Fifty-seven patients were seen again in followup visits.

Minor trauma and minor surgery. A variety of traumas resulting from accidents (small cuts from nails or glass, bruises, sprains, infected cuts, burns, a few lacerations requiring sutures, and one gunshot wound) was

grouped into this category. There were 160 such visits by 145 persons; no treatment was required during six visits; 142 injuries were treated. Three patients were sent to the emergency room of the university hospital for X-rays before definitive repair of sprains or lacerations. In nine visits, patients were treated at the clinic and referred to the university's outpatient department for a second diagnosis. Followup was not necessary after 105 visits; all other patients were seen one or more times, including one woman with a second-degree burn, who was seen daily for 2 weeks. Immunizations were given as required.

Dermatology. Seventy-three persons visited the clinic 78 times concerning dermatologic diseases, including various superficial fungal infections, seborrhea, impetigo, fever blisters, and psoriasis. The majority of patients were treated at St. Vincent's House; 17 were referred to other programs, mainly to the university's outpatient department and to the children and youth project.

Gastrointestinal illness. Persons visiting the clinic had a variety of conditions in this category, including suspected peptic ulcers, nonspecific gastroenter-

Table 5. Disposition of patients' initial visits to St. Vincent's House clinic, Galveston, Tex., October 1969–October 1971

Disposition	Number of visits	Percent of total
Treated.....	1,068	55.9
No treatment required.....	551	28.8
Referred to university hospital's outpatient department.....	156	8.2
Both treated and referred to university hospital's outpatient department.....	52	2.7
Referred to university hospital's emergency room.....	23	1.2
Referred to university's children and youth program...	21	1.1
Referred to private physician.....	9	.5
Referred to university's family planning program.....	4	.2
Referred to other programs.....	26	1.4
Total.....	1,910	100.0

itis, alcoholic gastritis, and hemorrhoids; two patients had viral hepatitis.

Seventy-four visits were made by 66 people; five required no treatment. In 11 visits the patients required referral to another source for diagnosis and treatment, including three patients who were referred to the hospital emergency room. Fifty patients were treated at St. Vincent's House; eight others were treated and referred to the university's outpatient department.

Dental disorders. A relatively large number of visits (70) were made concerning dental troubles: caries, abscesses, and, occasionally, reconstruction. Because St. Vincent's House had no facilities for dental work, almost all of these patients were referred to the dentists working with the university's children and youth project or its outpatient department or to private dentists. Aspirin for a toothache or penicillin for the treatment of abscesses were given to 14 patients at the clinic; nine of the 14 were referred to another program for treatment, as stated.

Miscellaneous conditions. There were 371 initial visits (19.4 percent of the total) for a variety of conditions. Numerically, these conditions were not sufficiently significant to warrant separate listing. Within this group, 51 visits of 49 persons were for treatment of ears and eyes, 46 visits of 45 persons were for obstetrical-gynecologic problems including unwanted pregnancy, 38 visits of 33 persons were for genitourinary infections, 32 persons were for hypertension, and 203 visits of 184 persons were for other reasons.

In all but the "other" category the patients were generally referred to other programs for

treatment of such conditions as decreased visual acuity, draining ears, pregnancy, infections, and hypertensive evaluation. Patients in the "other" category, which included nonspecific pains without physical findings, a variety of psychiatric difficulties, and persons requiring new appointments to the outpatient clinic, were treated and referred as necessary. Three persons were found to have congestive heart failure, previously undetected; they were treated at the clinic and referred to another program. Followup visits in each category were made if indicated.

Evaluation of Service

In the fall of 1971 a social researcher was employed by the department of preventive medicine and community health. She was given the task of designing a method for evaluation of the first 2 years of operation of St. Vincent's House clinic, October 1969 to October 1971. Because no evaluation techniques were built into the clinic's program, there first had to be a review of the data available at the clinic. Medical records concerning each patient, kept by the nurse, proved to be the only source of information.

Few standard procedures had been set for writing records; thus the information (social, demographic, medical, and so forth) varied from patient to patient. Information common to all or most medical records was formed into a data worksheet. The patients' medical records were then used to complete the worksheets. Each initial visit for an illness and all subsequent visits were recorded.

Discussion

The number of initial visits in 1971 increased 54 percent over

1970. The greatest increase was in visits related to venereal diseases, specifically gonorrhea. The total number of visits increased similarly, largely because of the increase in initial visits. Followup visits remained fairly constant.

The role of free clinics in the established system of health care has not been well delineated. Without decrying further the obvious deficits of the system (5-7), we suggested that free clinics have several roles to fill in the current delivery of health care.

Because of their location in so-called target areas, free clinics have the capability of attracting persons who otherwise do not avail themselves of established health services. Our experience confirms this point. Although we referred a relatively small number of patients to services operating satellite facilities (family planning and the children and youth project), we referred a larger number of patients to the university's outpatient department and emergency room, which do not operate satellite clinics.

The second capability of the free clinic, of necessity, is a knowledge of the resources available and their criteria for accepting patients. The ability of the free clinic to function as a portal of entry depends on achieving a certain rapport with persons whose priorities may be drastically different from those of the providers, and on maintaining flexibility in obtaining compromises between opposing interests.

Another role of free clinics is to provide direct services whenever feasible. The number and kind of services provided varies with the resources a free clinic is able to marshal, including personnel, equipment, supplies, and pharmaceuticals. For example,

we had an audiologist and an audiometer available for a limited period, which made audiometric screening possible for the school-age children. That the other direct services and sources discussed were reasonably adequate was evidenced by the large number of patients treated at the clinic.

Especially important is the ability of free clinics to treat problems and illnesses that have sociocultural implications, notably unwanted pregnancy, drug abuse, venereal diseases, and psychiatric illnesses. Our experience has been largely confined to drug intervention—to be the subject of a separate report—and venereal diseases, although we have counseled a few women with unwanted pregnancies. Since the period studied, we have added a mental health component to our clinic, but no data are available on this facet of the program.

Mention should also be made

of the extraordinary capabilities of nurses in the direct delivery of services within well-defined limits. Nurses have the talent to recognize and treat uncomplicated venereal diseases, minor traumas, and simple upper respiratory illnesses, although a physician must be readily available for consultation and direction. Nurses also fulfill a more traditional role in the followup and aftercare of patients, such as insuring that appointments are kept, explaining medical regimens, making home visits, and providing contact with assorted social and welfare agencies.

Our performance as a teaching and research unit has been varied and interesting. A number of students have used our patient population as a resource for research projects. Many others, including medical students, nursing students, occupational therapy students, and clinical associates, have participated directly in the operation of the clinic as a learn-

ing experience. We have found the clinic to be an excellent model for teaching students to identify community health problems and resources and for acquainting them with the intricacies in the delivery of health care. Their response to this type of experience has been generally favorable and beneficial.

Our experience in operating as a free clinic confirmed the value of this kind of delivery of health services. While we by no means deliver comprehensive health care directly, we have been in a position to provide limited primary care for our patients and to obtain additional primary, intermediate, or advanced services as indicated. Although this type of approach does little to reduce the fragmented condition of services, such a clinic can continue to function in a coordinating fashion once the patient has been introduced into one or more of the established health facilities.

CORNER, ROSEMARY (University of Texas Medical Branch), CARLYLE, M. KAY, BUNCE, HARVEY III, and MICKS, DON W.: *Appraisal of health care delivery in a free clinic. Health Services Reports, Vol. 87, October 1972, pp. 727-733.*

In October 1969 a free clinic was opened by the department of preventive medicine and community health, University of Texas Medical Branch, at St. Vincent's House neighborhood center to serve Galveston's indigent population. Services, including preventive medicine, screening, and diagnosis and treatment of minor illnesses, minor traumas, and venereal diseases, were developed through the use of existing resources and in response to patients' needs.

From October 1969 through October 1971 there were 1,300 patients, of whom 54 percent were males and 80 percent were blacks. Almost half of the patients were between the ages of 16 and 30 years old. The 1,300 patients made 1,910 initial visits, which required 1,836 followup visits. Approximately 17 percent of the visits were for well person care, 38 percent for venereal disease-related reasons, 9 percent for upper respiratory

illnesses, and 8 percent for minor traumas. The remaining 28 percent fell into various diagnostic categories. About 56 percent of the initial-visit patients were treated at St. Vincent's House; another 29 percent required no treatment other than preventive services; and the remaining 15 percent were referred to other health care facilities.

VISTA nurses were provided for staff work; a physician was available regularly through the department. Other volunteer professionals worked part time during the 2 years.

The role of the free clinic in the system of established care is important. Although free clinics do not provide complete primary care they can provide access to such care and can begin to provide continuity of care. In addition, a free clinic seems to be in a unique position to deal with socially unacceptable illnesses such as venereal diseases, drug abuse, and unwanted pregnancy.