Survival Potential and Quality of Care Among Free Clinics

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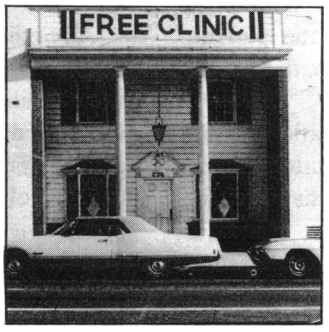

SINCE THE DEVELOPMENT of the pioneer Haight-Ashbury Free Medical Clinic in 1967, free medical clinics have emerged throughout the United States in an attempt to deliver health care to the poor, the socially disenfranchised, and those who seek medical care through untraditional channels (*1–3*). By 1972 more than 200 clinics in more than 30 States had been established to provide a variety of health and health-related services (*1*). In general, the free clinics have evolved in an unplanned, uncoordinated, and underfinanced fashion through the efforts of lay volunteers, students, and a few professional medical personnel. Additionally, the clinics have attracted special-interest groups who sometimes mobilize the clinics into organizations with social, educational, and political as well as treatment motives.

The free clinics are a controversial phenomenon. While proponents laud their need and acceptability within certain populations, others question their quality of health care and viability as a health care model (*3–7*). Some clinics apparently had been nonviable, because they have closed. At the height of the movement, the Los Angeles Council of Free Clinics claimed a membership of more than 30 clinics. By early 1973, however, no more than nine free clinics that offered medical services could be identified in Los Angeles (*4*). Standard reasons given by free clinics for closure have been inability to raise funds and recruit volunteer physicians (*2,3*).

A question is thus raised about the future viability of free clinics and the factors that appear critical for survival. If the free clinics survive, a more important question perhaps is: Can they deliver health care of acceptable quality? In seeking an answer to this question, we analyzed the survival status and quality of health care in five of the identified nine free clinics that deliver medical services in Los Angeles.

Methods

Between October 1, 1972, and March 1, 1973, Tennant attended the study clinics as a volunteer physician and treated patients at no less than 4 and as many as 10 separate clinic sessions per clinic. Day also made a few visits to clinics. The administrators of each clinic were interviewed, and details of each clinic's organizational structure, budget, type of patients treated, and medical procedures were obtained. Two of the five clinics were judged nonviable by the following criteria: (*a*) indebtedness to the point that staff salaries could not be paid and (*b*) inability to staff and provide medical services for less than one-half

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of the scheduled medical clinic sessions in the 6 months between October 1, 1972, and March 31, 1973. The status of these five clinics was tracked for survival outcome until July 1974.

To assess quality of health care in each clinic, the following criteria were employed:

1. Examining equipment was available and in working order
2. Medical record was maintained for each patient
3. Blood pressure reading and Papanicolaou smear were obtained before birth control pills were issued
4. *Neisseria gonorrhoeae* culture and serologic test for syphilis were performed for patients with suspected venereal disease
5. Abnormal blood pressure readings and Papanicolaou smears were followed up
6. Positive gonorrhea cultures and serologic tests for syphilis were followed up
7. Drugs were prescribed only by qualified physicians
8. Licensed personnel performed laboratory procedures including venipuncture.

Analysis of Clinics

Clinic 1. Clinic 1 is located in an inner-city, low-income area; about one-half of the patients are Mexican American (table 1). Its name was originally "free" clinic but it was changed to "family" clinic, although no fees were charged, to increase community acceptability. General medical services, including pediatric care, are offered four evenings per week. Approximately 15 to 30 patients are treated per session. Recruitment of medical personnel has not been particularly difficult, and some physicians and other medical personnel have attended once or twice per month for more than 2 years. Patients and other volunteer staff openly show appreciation for the volunteer efforts of physicians, which may assist in recruiting volunteers.

The organizational structure of clinic 1 can be seen in the diagram. A board of directors is active and meets regularly. Board members include medical personnel and community residents. A salaried, female lay administrator is responsible for recruiting volunteer medical and paramedical personnel. Generally, one physician functions as an unpaid consultant to the administrator. Funding for the clinic has come mainly from private donations, which amounted to about $30,000 in fiscal year 1973. (None of the clinics could produce a precise fiscal accounting of income, because many donations were nonmonetary.) Quality of care, as judged by the study criteria, appeared good (table 2). Drugs and treatment were prescribed only by a physician.

By the criteria used in this analysis, clinic 1 was viable, since it was not in debt and could staff and provide medical services for the majority of the scheduled sessions. In July 1974, it continued to thrive and appeared to have survival potential.

Table 1. Major characteristics of five free medical clinicals in Los Angeles

Characteristic	Viable [1]			Nonviable	
	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5 [2]
Location	Inner city	Suburb	Inner city	Suburb	Inner city
Primary clientele	Minority, all ages, poor	White, young, middle class	White, young, middle class	White, young middle class	Minority, all ages, poor
Usual medical problems	General medicine	Venereal disease, birth control	Venereal disease, birth control	Venereal disease, birth control	General medicine
Approximate budget in previous 1 year	$30,000	$40,000	$80,000	$80,000	$50,000
Scheduled clinic sessions per week	4	Less than 4	4	4	Less than 4
Salaried, nonmedical administrator	Yes	Yes	Yes	Yes	Nes
Board of directors meets regularly	Yes	Yes	Yes	No	No
Physician-consultant	Yes	Yes	Yes	No	No

[1] Clinic was not in debt and could staff and provide medical services for more than ½ of scheduled clinic sessions between Oct. 1, 1972, and Mar. 1, 1973.

[2] Clinic later became viable when it obtained a physician-consultant.

NOTE: 2 nonviable clinics had neither a board of directors that met regularly nor a physician-consultant.

Table 2. Quality of care assessment in five free medical clinics in Los Angeles

Criteria	Clinic 1 [1]	Clinic 2	Clinic 3	Clinic 4	Clinic 5 [2]
Examining equipment available and working	Inconsistent, examining tables were dental chairs	Yes	Inconsistent	Inconsistent	No
Medical record for each patient	Yes	Yes	Yes	Yes	Yes
Blood pressure and Papanicolaou smear obtained before birth control pills prescribed		Yes	Yes	Yes	Yes
Gonococcal culture and serologic test for syphilis for patient with suspected venereal disease		Yes	Yes	Yes	.....
Followup of abnormal Papanicolaou smears and blood pressure		Poor to nonexistent	Poor to nonexistent	Poor to nonexistent	Good
Followup of positive gonococcal cultures and serologic tests for syphilis		Poor to nonexistent	Poor to nonexistent	Poor to nonexistent	.....
Drugs prescribed only by physician	Yes	Yes	No	No	No
Only licensed personnel perform laboratory procedures including venipuncture	Yes	No	No	No	Yes

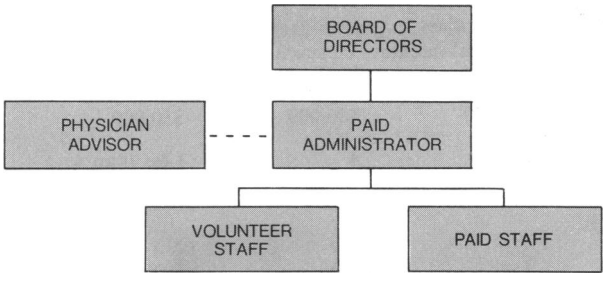
[1] Did not provide family planning and venereal disease services.

[2] Did not provide venereal disease services.

NOTE: there were deficiencies in quality of care at all 5 clinics.

Clinic 2. Located in a middle class suburb, this clinic serves primarily white adolescents (table 1). Medical services are limited to birth control and diagnosis and treatment of venereal disease, which are offered four evenings a week. Birth control services normally consist of pelvic examination, Papanicolaou smear, and issuance of oral contraceptives. Recruitment of volunteer physicians and other medical personnel has been erratic but sufficient to staff the majority of the clinic sessions. Some antagonism toward medical personnel was noted in the clinic; this may have hindered their recruitment. The administrator stated that some medical personnel discountinued volunteer services because they objected to such activities of the clinic as draft counseling, abortion referral, and giving birth control pills to minors without the knowledge of their parents.

Organizational structure of viable free clinics



The organizational structure of this clinic is identical to that of clinic 1 (see diagram). Funding, approximately $40,000 per year, has been obtained primarily by contracts to provide family planning and mental health services.

Quality of medical care was judged to be deficient in some areas (table 2). Followup was poor for patients with abnormal Papanicolaou smears and positive serologic tests for syphilis. Cultures for *N. gonorrhoeae* were processed outside the clinic, and the problems of logistics were such that reports of positive cultures were rarely received, even for specimens from patients with clinical gonococcal disease. Also, untrained volunteers often attempted to perform laboratory procedures, including venipuncture.

By the criteria used in this analysis, clinic 2 was viable. In July 1974, it continued to thrive and appeared to have survival potential.

Clinic 3. Clinic 3, located in the inner city, principally serves white, middle class youth (table 1). It provides primarily venereal disease and birth control services like clinic 2, and its organizational structure was identical to that of clinics 1 and 2. Funding has been provided mainly by a public contract to conduct family planning services and by private donations. The contract amounted to about $80,000 in fiscal year 1973.

The most impressive aspect of clinic 3 was the lack of order during clinic hours. Physical space

was far too small for a patient load of 50 or more patients per evening session. No one appeared to be in charge, and the organization of patient flow was left to the volunteer physician.

Quality of care was negligent in some areas. On two occasions nonphysicians were observed to be performing pelvic examinations and prescribing medications. One person was a medical student who wanted practical experience, and the other was an untrained young man who said that he enjoyed examining and treating people. Neither, apparently, had been questioned about his credentials. As in clinic 2, problems of follow-up on patients with abnormal Papanicolaou smears and positive serologic tests for syphilis were evident. Untrained persons performed laboratory procedures, including venipuncture.

Clinic 3 was viable according to our analysis criteria. In July 1974, it continued to thrive and appeared to have survival potential.

Clinic 4. Clinic 4 was nonviable, since it was in debt and unable to staff and provide medical services for at least one-half of the scheduled sessions. Within a few months after this analysis, the clinic was closed.

Clinic 4 was located in a predominantly white, middle class suburb (table 1). It provided general medical services with an emphasis on venereal disease, birth control, and heroin detoxification. About 75 to 100 patients patronized each of the clinic's four sessions per week. The organizational structure differed slightly from clinics 1, 2, and 3. Although there was a board of directors, it rarely, if ever met. There was a paid, nonmedical administrator but no physician-consultant.

The clinic director and other personnel stated that medical professionals, including physicians, were generally insensitive to patient needs, did not understand the free clinic movement, and had always tried to dictate medical practice. This attitude may have contributed to the agency's difficulty in recruiting volunteer physicians and other medical personnel since the staff reported little success in this effort. The following observations may demonstrate these staff attitudes. A volunteer military physician was chastised by a nonmedical, clinic volunteer because he preferred intramuscular penicillin rather than oral tetracycline for treatment of gonorrhea. The physician left the clinic immediately, stating he did not need to volunteer his time under those conditions. On another occasion, a female volunteer physician was told by two, nonmedical female staff members that her services were not wanted because they preferred male physicians.

Donations and a grant from the local community supported the clinic. Although approximately $80,000 had been raised in the preceding 12 months, the clinic was now in debt. The reason given for indebtedness was that eight nonmedical staff had been hired.

Quality of care deficiencies were similar to those of clinics 2 and 3 in that followup of patients with abnormal Papanicolaou smears and positive tests for venereal disease appeared to be inconsistent. Examining equipment was adequate, and otoscopes and stethoscopes were in working order.

A major deficiency observed was that nonmedical personnel prescribed and dispensed antibiotics and other medications. This practice was especially evident in the heroin detoxification program in which nonprofessional counselors dispensed restricted drugs. Following our initial visits, the clinic continued to show evidence of nonviability. The prescribing and dispensing of drugs by nonphysicians came to the attention of legal authorities, and the local community discontinued grant support.

Clinic 5. Clinic 5 is located in an inner-city, low-income area. It provides general medical services, including pediatric care, to Mexican American families. Approximately 20 to 30 patients are treated during three clinic sessions per week.

The organizational structure was identical to that of clinics 1, 2, and 3, but the agency lost its physician-consultant to the military draft just before our analysis. This loss created considerable difficulties since this physician was the main means of recruiting other volunteer physicians. As a consequence, less than one-half of all clinic sessions were held. Funding amounted to approximately $50,000 in fiscal year 1973; however, indebtedness was incurred by employing paid staff. This clinic was nonviable in terms of the analysis criteria.

Quality of care evaluation revealed that examining equipment was frequently missing at clinic sessions or not in working order. The volunteer physician usually found it necessary to bring examining tools to the clinic to insure proper examination of patients. Donated drugs were stocked in the clinic, and they were occasionally

prescribed and dispensed by nonmedical staff.

Shortly after our visits for analysis, the administrator managed to recruit a new physician-consultant who was able to recruit volunteer physicians and oversee medical procedures. In addition, a new public contract to provide family planning services was obtained. In July 1974 this clinic was classified as viable, and its prospects for survival appeared optimistic.

Survival Potential

Although no statistical conclusions can be drawn from a study of only five free clinics, their history indicates that a particular organizational structure is associated with viability and survival potential. This observation is not surprising; a proper organizational structure is now recognized as a crucial determinant of success or failure of health care organizations (*8*). The clinics in this analysis that had a specific organizational structure (see diagram) have survived for 3 to 6 years and appear to be capable of operating in the foreseeable future. Clinic 5, although nonviable at the time of analysis, became viable when it was able to maintain this organizational structure. Clinic 4 did not maintain or desire this organizational structure, and it eventually closed.

The maintenance of the organizational structure appeared to depend, primarily, upon the ability of the paid administrator In these clinics the administrator normally recruited the physician-consultant and most staff, and he or she largely determined the degree of involvement of the physician-consultant and board of directors. The board of directors made decisions relating to medical treatment, administrative procedures, and community acceptance. The physician-consultant may or may not have been on the board of directors. He was used by the administrator principally to recruit volunteer physicians, assist with fundraising, and advise on medical procedures.

Quality of Care

Table 2 summarizes the criteria used to assess quality of care in the clinics. These criteria were used because they are generally accepted practices and procedures for ambulatory care. We are not attempting to establish these criteria as a standard of assessment.

Deficiencies were noted in all five clinics, and our observations tend to support claims that quality of care is lacking in free clinics (*5*). Some deficiencies, such as poor followup of abnormal Papanicolaou smears and the prescribing and dispensing of drugs by nonphysicians, are cause for concern. Deficiencies in quality of care did not appear to be particularly related to viability and survival potential of the clinics, since the viable clinics often exhibited the same deficiencies as clinic 4, which closed.

Discussion and Conclusion

Medical care organizations such as free medical clinics do not lend themselves to the precise studies that can be achieved in clinical research. Consequently, a clear-cut delineation of survival factors and quality of care must necessarily be somewhat subjective. Although no statistical conclusions can be drawn from a study of five clinics, our analysis revealed a simple but specific organizational structure that is associated with the survival of a controversial model of health care. Ambulatory clinics other than free clinics may find this structure useful. Maintenance of the organizational structure appeared to depend on the talents and skills of the clinic administrator.

There were deficiencies in the quality of health care delivered in the clinics. Of particular concern were the poor followup of Papanicolaou smears and the prescribing and dispensing of drugs by nonphysicians. Quality of care deficiencies should be corrected, since some free clinics appear to have good survival potential in the current health care delivery system.

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