Neil Kalsi, a fourth-year medical student at Saint Louis University, is not only a dedicated student but also a social activist working to create substantial change in the world. It was through Neil, an inspiring mentor over the past four years, that I came to be involved in a unique project and learning experiment. The idea was simple enough: Neil wanted to enlist the help of undergraduate students in creating a comprehensive “directory-of-sorts” that would contain necessary information on all of the free health clinics within the city with the hope of increasing accessibility to care for people who need it. Yet with the complicated web of different clinics, as well as the many other factors of St. Louis’ healthcare, it became clear that this simple idea would not be simply achieved. To start, Neil created a “Community Perspectives in Healthcare” course. With the purpose of gaining a comprehensive understanding of healthcare in St. Louis, our class of five met throughout the year discussing various healthcare topics ranging from the history of healthcare in St. Louis, to LGBT health issues. In addition, we went into the community to interview those who used the city’s clinics to study their perception of each clinic. Ultimately, our “directory-of-sorts” evolved into a directory that was mutually beneficial to both patients and clinics—one that would provide people with the necessary information to receive care, and also provide clinics with feedback in order to better meet the needs of their patients.

The goal and purpose of our research was to help us gain a better understanding of why people chose particular clinics, and what factors affect their decisions. To accomplish this, our class went out into the community to talk to people, conducting close to 120 “surveys” (though they were formatted more as conversations). These conversations took place at various locations throughout the city, including Places for People (a mental health and community center
located on Lindell Boulevard), St. Teresa and St. Bridget Catholic Church (located on North Grand), and St. Augustine Catholic Church (located on Hamilton Avenue just north of The Loop).

Our questions during each survey included simple things such as: “Have you ever heard of (X clinic) in St. Louis?” and “do you know what services (X clinic) provides?” We also asked evaluative questions such as: “What good or bad things have you heard about (X clinic)?” Our hope was that by asking people about each clinic’s reputation, we would gain an insight into why people decided to visit a clinic or not, as well as what services they thought were best performed at each clinic. By compiling this data, we hoped to gain a comprehensive understanding of each clinic in St. Louis.

The first class topic in Community Perspectives in Healthcare was “The History of Healthcare in St. Louis,” taught by Dr. Fred Rottenek from SLU’s Department of Family and Community Medicine. The second topic was a viewing of the documentary entitled Homer G: A Jewel in History – A Premier Black Hospital in St. Louis (Godwin, Nwoffiah, and Stroud). The purpose of these opening classes were to give us an introduction to the history of hospitals in the St. Louis area, as well as an explanation as to why the location of our hospitals has resulted in certain health outcomes in our city. We learned that St. Louis, like many Midwestern U.S. cities, suffered from a strong urban flight that decimated the city’s population. Prior to this, St. Louis had been known as a vital center for African American culture and life; from the 1930’s to the 1970’s, St. Louis maintained the largest and most prosperous black community in Missouri (Carter 2009). Opening its doors in 1937, Homer G. Phillips Hospital became the city’s only hospital for African Americans. During its operation, it served as one of the few hospitals in the United States where African Americans could train to become doctors or nurses. In fact, by 1961,
Homer G. had trained more African American doctors and nurses than any other hospital in the world. Following the desegregation of hospitals in 1955, Homer G. remained a vital health center to the African American community until its closure in 1979.

Multiple events and trends in St. Louis, as well as the nation in general, affected the city’s population and hospitals such as Homer G. Phillips. Following the construction of the highway system and the drastic rise in suburbanization, St. Louis saw a steep drop in the city population. Fueled by racial as well as economic tensions, upper class (and mostly white) citizens abandoned the city, leaving lower-income African Americans within the city. By the 1970’s, Lyndon B. Johnson’s “Great Society” policies had come to an end, further deepening the struggles faced by many of America’s urban poor. This, combined with the population’s unabated flight into the suburbs, devastated the St. Louis tax base, leaving institutions such as schools and hospitals such as Homer G., with insufficient operating funds. Many of St. Louis’ African American citizens had lost their key resource to medical care.

In addition to learning about the history of healthcare in St. Louis, we discussed the implications that our city’s past has had on today’s health outcomes. By looking at a current map of the city’s hospitals and clinics (see Figure 1), it becomes clear that certain sectors of the city have an abundance of health resources, while other sectors have little to no health resources. Areas such as Forest Park (where hospitals such as Barnes-Jewish are located), have high numbers of clinics, as does the 64/40 corridor, which is lined with hospitals leading out into the county. Furthermore, if one looks at the concentration of primary care providers (see Figure 2), they follow this same trend. Looking at North St. Louis (areas located north of the 64/40 corridor and south of I-70), one finds a stark difference. Almost no hospitals, clinics, or primary care providers can be found in this section of the city. The reasons for this disparity in health
resources lie in socio-economic history of St. Louis. If one looks at average household incomes by zip codes in St. Louis, the lowest incomes are found within the defined North St. Louis area. Additionally, if one looks at the racial make-up of the different zip codes of St. Louis, one finds that the highest percentage of African American populations live in the North St. Louis area. Those who currently live in North St. Louis suffer from a lack of access to care because of the mistakes of St. Louis’ past, as well as the pervading racism that has been part of the city’s history.

This lack of access to care for those living in St. Louis has had a drastic impact on the health outcomes in the area. According to the Missouri Department of Health, St. Louis’ rates of sexually transmitted diseases are two-to-seven times higher than the state’s rates. Additionally, death rates due to diabetes, heart disease, and lung cancer are significantly higher than the rest of the state. This is only worsened by the fact that 32% are more likely to be obese than people elsewhere in the state. Yet these problems are not evenly dispersed throughout the city. By looking at the chronic and acute disease rates in the city (see Figures 3-12) it becomes clear that different parts of the city suffer from very different levels of disease. Again, a distinct pattern can be found in the North St. Louis community. A reliable indicator of healthcare in an area is often the infant mortality of the area (the number of babies out of every 1,000 babies who die before turning one). In The United States, the average infant mortality rate is 7 out of every 1,000 babies. Yet in some zip codes of North St. Louis, the infant mortality rates reach a staggering 23 out of every 1,000 babies, more than three times higher than the national average and comparable to the infant mortality rates of some developing nations. Considering that these rates exist within miles of zip codes with average infant mortality rates, this disparity can be shocking.

Additionally, these health outcomes are not isolated difficulties for the North St. Louis community. Connected to these health outcomes are problems with access to education,
jobs, and safety. The socio-economic factors that exist within the city are incredibly powerful determinants in the community’s health. It is not a coincidence that North St. Louis contains the lowest concentration of high school graduates (see Figure 5), the lowest average household incomes (see Figure 3), and the highest homicide rates (see Figure 13) in the city. All of these factors— culture, gender, environment, social status, race, income—become dependent on each other and influence the level of the community’s health. According to the U.S. Department of Health and Human Services, a person’s education level is one of the strongest indicators of his or her health. Because factors such as low education levels continue to plague the North St. Louis community, the health outcomes of the area continue to be significantly lower than the rest of St. Louis.

Another topic we covered in the Community Perspectives in Healthcare class was the significant role that racism plays in healthcare today in America. We examined this issue through two lenses. First, was through a book by John A. Rich, M.D., M.P.H entitled Wrong Time, Wrong Place: Trauma and Violence in the Lives of Young Black Men. Written in 2011 about the rise in violence taking place in Boston, Rich discussed the various social factors that seem to be affecting the African American population, and in particular, African American males. Rich points out that African American males live in a much different world than the rest of us. In 2006, the homicide rate for black males ages 15 to 24 was 92 in every 100,000. For white males in the same age range, it was 4.7 for every 100,000. This makes the homicide rate for young black men nineteen times higher than for young white men.

Rich points out in his book that he was tired of treating men off the streets, just to have them end up back in the hospital days later due to gang-related crime. He argues that if we are to make significant changes to these statistics, we must treat these men as culturally and
emotionally injured. To Rich, viewing these problems as injuries mean that they can be treated, and one day healed. By addressing the social factors that have caused African American men to be demonized, we can begin to change the effect it is having on our healthcare system. How exactly does this affect our healthcare? Aside from the incredibly high mortality rates African American males face, The Medical Journal of Preventative Medicine points out that for 2007 alone the cost of American homicides and interpersonal violence was $33 billion lost in productivity and $4 billion lost in medical treatments. For Dr. Rich, the solution to this is simple: “ultimately I believe that if we want to make ourselves safe, if we want to end the high levels of violence affecting young black men, we must focus on their safety: the very people we have blamed for making the community unsafe. We are only as safe as they are. The same safety we desire, they desire” (Rich 157).

The second lens by which we examined the role of racism in healthcare was through Larry Adelman and Llew Smith’s documentary television series: Unnatural Causes: Is Inequality Making Us Sick?. We watched an episode that documented how African American women in America continue to suffer from high rates of pre-term births as well as infant mortality, regardless of their socio-economic status, compared to their white counterparts. The film discussed a study by neonatologists James Collins and Richard David, in which they studied the maternal health outcomes of African American women, white women, and African-immigrant women. They found that African American women’s babies weighed significantly less than the other groups, and furthermore found that within one generation of immigration, African-immigrant began experiencing these same outcomes. But what could be causing these effects that were independent of income, as well as biology? Fellow neonatologist Michael Lu argues that these outcomes are the result of chronic stress due to racism within our culture. African
American women experience racism daily, causing their stress hormones to consistently be elevated, which is known to trigger pre-mature labor. They argue that it is the subtle and subversive stressors of everyday life for an African American that is causing such drastic differences in their health.

Another topic that we discussed in our course was the issue of LGBT healthcare. Our class had the pleasure of having Adrian Zimbelman, a transgender man who works with LGBT youth in St. Louis to come and speak about his experiences with healthcare in the LGBT community, as well as the difficulties he and many other transgender people face in accessing care. In terms of LGBT healthcare, the LGBT community faces a myriad of obstacles and health disparities when compared to the rest of our community. According to the U.S. Department of Health and Human Services, the LGBT community faces increased risks of psychiatric disorders, substance abuse, suicide, violence, and sexually transmitted diseases. Because of this, it is crucial that this community be able to have easy access to healthcare. Yet today, many in the LGBT community still face difficulties in receiving proper care. One of the largest obstacles is that most care providers simply do not know that their patients are LGBT. In a study of pediatricians and adolescent medicine specialists in Washington DC, 68% reported that they did not usually discuss sexual orientation when taking a sexual history, and 90% reported having reservations about discussing sexual orientation during visits. Similarly, another study of LGB 18- to 23-year olds reported that 78% had not disclosed their sexual orientation to their clinician, but 67% reported that they would have liked to (Zimbleman).

This barrier between patient and physician can easily be eliminated through education and tolerance on the side of the care provider. Dr. Harvey J. Makadon, a gay physician and author of “Improving Healthcare for the Lesbian and Gay Communities,” discusses an instance
when he faced a barrier in visiting a physician due to the medical system. He writes, “At the registration desk for a physician’s practice, I was asked, rather publicly, whether I was married or single. When I replied that I had a partner, a second office worker next to the registration clerk leaned over and loudly exclaimed, ‘He’s single.’” The lack of language and avoidance of addressing topics of sexual orientation have resulted in gaps in LGBT patient history, ultimately affecting their overall health. Dr. Makadon suggest that simple changes, such as rewording the language in patient history forms as well requiring that all staff be educated on LGBT health issues would help to create a more welcoming environment in clinics, potentially making a big difference in not just the patient-physician relationship, but also the patients’ health.

From Adrian’s perspective, our class was able to get a glimpse into the difficulties of transgender healthcare, particularly here in St. Louis. Adrian, who is a trans-man working with the LGBT community in St. Louis, shared his story with us and his journey of physically becoming male. One of the first difficulties he faced was simply finding a doctor in the U.S. who performed gender-reassignment surgeries. Because of the stigmas placed on transgender people, many physicians simply do not want to become involved in the operations. Additionally, Adrian had to fight his insurance company repeatedly in order to afford his surgeries. Because most insurance companies view gender-reassignment surgeries as simply “cosmetic” procedures, and not necessary procedures, they often will not cover the costs of them. Beyond these difficulties, Adrian explained that trans-men have a difficult time finding doctors willing to prescribe testosterone to them, as well as affording it because of high costs. Yet explained that, “every day not on testosterone is a day of life wasted.” Because of examples like this, Adrian explained that the LGBT community in St. Louis has small circle of doctors that they recommend to each other, because these doctors are willing to work with them and create an open environment in the clinic.
We learned that a lot still needs to be done in St. Louis to help make our LGBT community more accepted in the healthcare system and ultimately improve the health of their community.

The last topic of our course was a discussion on FQHCs, or Federally Qualified Health Centers, and the role that they play in St. Louis. A Federally Qualified Health Centers is a type of healthcare provider that receives reimbursements from the US Department of Health and Human Services. Established in 1975, FQHCs receive grant funding under section 330 of the Public Health Service Act, allowing them to provide affordable care to America’s most needy.

One of the requirements of an FQHC is that it must be located in a medically underserved area. A medically underserved area, as defined by the US government, is determined by: the ratio of primary care physicians per 1,000 people, the infant mortality rate, the percentage of the population below the poverty line, and finally the percentage of the population that is age 65 and over. When combined, a score of 62.0 or less out of 100 on the Index of Medical Underservice qualifies an area as a medically underserved area.

The role of FQHCs is to provide preventative and primary care to populations in need. FQHC services generally include primary care, dental care, mental health care, and often substance abuse treatment. To gain a better idea of the large population size that FQHCs serve, in 2009, 18.8 million people’s care from an FQHC. Of these people, 90% have an income below 200% of the federal poverty threshold and 63% are members of a minority group (“Medicare” 117). In St. Louis, there are five FQHCs: Family Care, Grace Hill, Myrtle Hilliard Davis (which all serve areas of north and south St. Louis), the Betty Jean Kerr People’s Health Centers (which serve both the city and the county), and Crider Health Centers (which serve the St. Louis county and surrounding counties). Family Care, Grace Hill, and Myrtle Hilliard Davis are primarily the main centers that take on the enormous task of caring for St. Louis’ poor and needy. Over three-
quarters of these centers’ patients live below the poverty line (BHC), meaning that for many in St. Louis, these clinics represent the sole resource for receiving any form of healthcare. Grace Hill is currently the largest FQHC in the city, with five separate locations in St. Louis, with Family Care and Myrtle Hilliard Davis both having 3 locations. Grace Hill, for its size and for the large amount of patients that it sees, generally receives the most grant funding each year for operations, making it a very successful clinic and a vital resource in the city. With this information in mind, our group then looked at these FQHCs, as well as other clinics in St. Louis, to see how patients viewed and the community at large viewed them.

Upon completing our research, our class discovered that our project had evolved and changed from what we had originally set out to do. Our original research question was to determine why people decide to go to certain clinics over others. Initially, we thought this would be a rather easy question to answer. Yet we soon realized the complex factors that go into this; instead, our research gave us an in-depth look into how people in St. Louis perceive the various clinics, and into basic trends that people considered to be good and bad in a clinic. Our initial goal was to evaluate the clinics of Grace Hill, Myrtle Hilliard, People’s Health Center, Family Care, SLU Hospital, the Health Resource Center, CHIPS, Connect Care, and Cardinal Glennon Hospital. We found that in the 124 interviews we conducted, places such as Cardinal Glennon and CHIPS were not commonly accessed for care, whereas places such as Grace Hill and Connect Care had very high rates of use. In fact, Grace Hill, being the largest FQHC in St. Louis, was the most widely known and recommended clinic, with many people giving positive comments and remarks about the care given there. Other widely known clinics included People’s Health Center, Connect Care, and SLU Hospital. Yet for some reason we were unable to identify in our surveys why clinics such as People’s Health Center, which were well known by people,
had such low levels of access. For example, twenty participants had heard of People’s Health Center, making it the second most well known clinic in St. Louis within our survey. Yet even with a positive perception by people, only five people had visited the clinic for care. It is possible that some kind of barrier exists between people and this clinic that not even our survey and research were able to determine. Other clinics, such as the Health Resource Center, Family Care, and Myrtle Hilliard all had moderate levels of name recognition throughout the community, with around seven to eleven people having heard of them. A positive sign for these clinics that we found though is that of those people that had heard of these clinics, almost all of them chose to go to these clinics for care and were pleased with the level of care they received.

One of the biggest, or most educational, results of our project was that we gained a better understanding of what factors people consider important in a clinic. When asked what aspects about a clinic they found to be good, the most common responses were that the wait time was short, the entire staff was friendly and professional, communication was clear between the patient and the doctor, and that the clinic was affordable. When asked what the negatives aspects were of various clinics, many responded that long waits, inconvenient locations, low levels of cleanliness, and unprofessional staff were big deterrents in whether or not they visited that clinic. From this, we concluded that if clinics in St. Louis want to improve their reputation and number of patients, changes in simple things such as professionalism and cleanliness could help to change this. Considering that factors such as long waits and affordability are difficult factors to change in our city’s already over-burdened system of clinics, we believe that by spreading the word about other clinics that are less utilized, such as People’s Health Center, the burden of care can be shifted off of heavily-utilized clinics such as Grace Hill, thus shortening wait times and hopefully allowing for longer doctor visits and ultimately, a greater level of care. We found that
clinics such as the Health Resource Center are already using a map of the different clinics in the area so that when patients are not able to come to their clinic (because the Health Resource Center only sees 12 patients per day) they are able to recommend them to another clinic. We believe that if other clinics were to use this map and recommend each other to their patients, the safety net that is our city’s clinics would grow much larger.

Now that Community Perspectives in Healthcare is over, my understanding of our nation’s health, and more particularly St. Louis’ health, has grown tremendously. The American medical culture today focuses so much on acute and tertiary care. Yet it has become incredibly clear that if our citizens are to truly take care of each other, the emphasis must switch to a much more holistic approach that encourages primary care visits, takes the social determinants of health into consideration, and focuses on removing the barriers in place that prevent or dissuade people from seeking care. St. Louis is an incredible city with a great safety net in terms of healthcare for its poor. Yet so much more can be done. These clinics still remain understaffed, underfunded, and highly disconnected from each other. As someone planning to enter the medical profession, I hope to take these lessons I’ve learned in this project and apply to creating positive change in our healthcare system. Although making significant systematic change may be too much a task for one person, a single person can make a big difference in the lives of those he or she cares for. I am incredibly grateful to Neil Kalsi for opening my eyes to the disparities that exist in our nations’ health, as well as showing me that it is possible to work for change, and to seek solutions that will end these disparities.
Figures

**Figure 1:** Location of Hospitals and Clinics in St. Louis

**Figure 2:** Primary Care Physician Office Locations
Figure 3: Average Household Income

Figure 4: Racial Polarization

Figure 5: High School Graduates

Figure 6: Avoidance Hospital Admits
Figure 7: Infant Low Birth Weight

Figure 8: Infant Mortality

Figure 9: Syphilis Incidence

Figure 10: Chlamydia Incidence
Figure 11: Homicides  
Figure 12: Overall Death Rates
Example of Questions Asked:

Participant is handed a list of organizations and the following questions are asked about each Organization:

1) Have you heard of this organization?
2) Have you used it?
3) Do you know what services this organization offers?
4) Would you recommend this organization?
5) What did you like and dislike about the organization or, if you have not used this organization, what good things and what bad things have you heard about it?
6) Would you recommend a different organization for these particular services?
7) What resources do you recommend for the following?
   - General health check ups?
   - Women’s health (if interviewing a female)
   - Children’s care
   - Dental
   - Diabetes care
   - Mental health needs/illness
   - Substance abuse
   - Medications
8) Do you have any other comments or questions?
### Example Data Set: People’s Health Center

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q5</th>
<th>Q4</th>
<th>Q6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Y</td>
<td>Dental, Prenatal, Complete health care</td>
<td>D - I didn’t feel like they listened to me, I know my body</td>
<td>Well, I had a bad experience</td>
<td>Not really</td>
</tr>
<tr>
<td>y</td>
<td>y</td>
<td>physicals</td>
<td>L - Dr. Bochanan, I liked her, took holistic approach, she knew her stuff. D - Wont cover psychiatric services and really expensive, $50 for those services.</td>
<td>y</td>
<td>Don't know any others</td>
</tr>
<tr>
<td>Y</td>
<td>n</td>
<td>the basics</td>
<td>L - local, high quality, tied in with medicare system, looks fancy.</td>
<td>y</td>
<td>n/a</td>
</tr>
<tr>
<td>y</td>
<td>n/a</td>
<td>n/a</td>
<td>L - pretty good, take care of people without insurance. D - service is slow.</td>
<td>y</td>
<td></td>
</tr>
<tr>
<td>y</td>
<td>n</td>
<td>n/a</td>
<td>L - good resource</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>y</td>
<td>y</td>
<td>children’s care, women's care</td>
<td>L - people are really nice, doctor came right away, care was awesome, a doctor went out of her way to do what she had to do. Money wasn’t an issue. She would go the extra step to make sure we were okay.</td>
<td>Y</td>
<td>n/a</td>
</tr>
<tr>
<td>y</td>
<td>n</td>
<td>Dental</td>
<td>L - a friend used it for dental, said it was nice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>y</td>
<td>n</td>
<td></td>
<td>L - heard it was faster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
<td>Dental, Prenatal, Complete health care</td>
<td>l-service and staff was ok D - little far</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>N/A</td>
<td>have heard it's good for community health</td>
<td>N/A</td>
<td>no- people recommended this</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Loopholes with &quot;Peoples&quot; for qualification. Issues with</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>


