

Solidarity not Biomedicine – Common Ground Health Clinic’s “New Model” of Providing Healthcare

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“The alternative model was established in the very beginning. . . the initial founders [said] wow, we have this opportunity to provide the kind of healthcare that we would like to provide. . . to provide what we would want for us” [11].

LONG-TERM VOLUNTEERS at Common Ground Health Clinic (CGHC) in New Orleans speak resolutely, passionately, and extensively about their “New Model” of healthcare. Important to their project is not just providing any type of “medical care” to the previously underserved New Orleans neighborhood of Algiers but providing a specific type of care – “what we would want for us.” This goal is explicitly political, like that of the Black Panther clinics, and it challenges the methods and discourse of traditional biomedicine. This paper

aims to articulate the components of the Model of the intervention that it resulted in, with an eye toward how it relates to traditional biomedicine, and constitutes a discursive intervention into biomedicine. The Clinic Model¹ incorporates some aspects of biomedicine, and blends them with aspects of street medic/anarchist philosophy. It is worthwhile to analyze their *Model* because it explicitly addresses deficiencies in biomedicine’s approach, and incorporates those criticisms into the particulars of how a clinic should function. However partially, their Model of intervention puts theory into practice in a way that clarifies the theory and demonstrates how a discursive² intervention could be enfolded into a “traditional” medical setting.

It is important to note that accounts of the “New Model’s” specifics differ and have evolved over time. Within the first week of the Clinic’s operation, they wrote down “formal” principles of operation (the original copy of this still hangs in the Clinic’s administrative building), many of which have been retained. But they were written to reflect the needs of a first-aid station in a disaster zone, not a permanent primary care clinic. As the conditions of disaster receded, the Clinic’s services narrowed, codified, and became more permanent. They developed a decision-making body, and learned in more depth the needs of the community, so they adapted their services. Rather than document all the ways in which the Model has evolved, this paper will articulate the Model as it was understood and functioned in the summer of 2006. By this time, working practices and philosophies had been stabilized into a “Model” which no doubt continued to evolve, but contained stable elements. This paper draws from accounts of the Model that are at times fragmented and incomplete and orders them – to the extent that is possible – into a coherent framework. This is done primarily through piecing together long-term volunteers’ explanations of what the Model is, does, and should do.³ Names for components of the Model are chosen for clarity – some of the terms long-term volunteers coined, and some I coined in order to avoid awkward or vague phrasing.

1 Introduction to the Clinic’s Model – Solidarity, not Biomedicine

“4. This space aspires to work in solidarity with this community, not as charity for it” [2].

Clinic volunteers are not social theorists, in the sense that they may have

¹This paper examines the Clinic’s Model of operation, which differs from their everyday reality of operating. Enacting all of the Model’s principles in full would require funds, community connections, and time surpassing what CGHC has at its disposal. For example, as the conditions of disaster post-Hurricane Katrina receded, the Clinic was too understaffed to conduct home visits with the regularity that the Model calls for.

²See definitions on page 20.

³This is supplemented with data from my experience working in the Clinic and being acclimated to this Model, as well as information from documents that spell out aspects of the Model as convergent validation would dictate.

not read Kleinman, but they designed their intervention as an intentional departure from what they understand as the problems with biomedicine.⁴ Some of their criticisms resonate with the interpretations of biomedicine held by social scientists and public health researchers who study health inequities and institutional racism, critical theorists' analysis of medical perception, and anthropologists' studies of biomedicine, and some are inflected with a specifically anarchist critique. The intervention can be divided into three categories – redefining “patient,” restructuring the doctor-patient interaction, and rethinking the purpose of medical intervention. This process of redefining is what makes the Clinic’s intervention specifically discursive. They are altering what can and cannot be said about a patient, in terms of what is both possible and acceptable.

The Model is grounded in the discourse of street medicine/anarchism and the goal to “provide quality healthcare.” This is emblemized in the Clinic’s motto “this is solidarity, not charity.” This phrase plays on the double meaning of the word “charity” – they aim to provide a different, and better, form of healthcare than Charity Hospital. Additionally, their new and better form is specifically “solidarity,” a term that is a mainstay of anarchist philosophy. It means they want to provide healthcare “with” and not “for” the Algiers community.

“Solidarity not charity” also showcases an anarchist practice that makes them well suited to engage in a specifically *discursive* intervention. Anarchists often reclaim terms. I have written elsewhere about an example of this in street medics’ use of the term “do no harm.”⁵ Anarchists choose to make a direct critique of what the term stands for through use of that term, rather than coin a new term. Reclaiming is an acknowledgment among anarchists that discourse, not just language, must be changed. Because discourse defines what can and cannot be said rather than what is said, re-coining simply changes what is said, and is insufficient. Reclaiming alters what “what is being said” *means*, which is equivalent to changing what can and cannot be said. Many reclaimed terms accompany the acts of redefinition outlined in the following sections.

2 Redefining the patient

The Clinic redefines the patient in three ways – it emphasizes holism over reductionism, posits a tight relationship between the individual and the community, and argues structural determinacy over individual responsibility. These three are difficult to describe separately because they build off of and depend upon one another – holism necessitates a structural determinacy approach and so on. All three of these redefinitions serve to change the terms on which “patient” and “medical clinic” can be understood. Clinic volunteers both avow them philosophically and practice them in the operation of the Clinic.

⁴An example from the volunteer orientation handbook illustrating this point: “We are not seeking to emulate government controlled free clinics, in which patients have little say about the care they receive, or the clinics where doctors spend their residencies with little oversight while serving lower-income communities” [4].

⁵[Stern wrote about street medics’ use of the term “do no harm” in Chapter 2 of the thesis from which this paper is excerpted [24] – ed.]

2.1 Holism – “Patient-centeredness” and “focus on the whole person”

“1. Our first goal is to focus on our patients’ needs. Egos, agendas, political, religious, medical or otherwise must not interfere with this” [2].

While physical reductionism is a major tenet of biomedicine, holism⁶ is a major tenet of the Clinic Model. “Holism” means that it is vital and transformative to consider the patient as a whole person with aspirations, tribulations and desires, as well as a social and cultural context. Clinic volunteers acknowledge the reduction of “person” to “body” in biomedicine, and see it as a larger trend in Western culture [22, 3]. The Clinic’s Model argues that biomedicine’s reductive dynamic not only impedes the improvement of health, but makes patients sicker in specific ways.

The Clinic responds to this reductionist rubric through practices in which “the patient comes first” and which generate “more respect for the human” [11]. Patient-centeredness is another of the Clinic’s reclamations – “patient-centeredness” is often a goal of traditional medical clinics, but it has been reengineered in the Clinic setting. This is because implicit in “patient-centered” is a redefinition of “patient” that includes social, psychological, and cultural attributes in the term. Therefore patient-centeredness means creating an environment in which patients feel validated, respected, and comfortable. One volunteer explains “are you going to go [get medical care] where you could get a massage on the sidewalk while you waited or are you going to go where there’s a whole line of armed guard in camouflage” [10]? Implicit in this question is the idea that a “patient” has needs beyond bodily needs, and that the Clinic aims to make them comfortable socially as well as treat them medically.

This emphasis on the patient as a social, cultural, and biological being becomes evident from the moment the patient enters the Clinic due to the Clinic’s approach to intake. In a traditional medical clinic, intake is the part of a visit where the patient meets with a nurse, medical assistant, or EMT, who takes a brief medical history and assesses the nature and seriousness of the patient’s present illness. As one of the seasoned doctor-turned-Clinic volunteers describes, “in a typical clinic, [intake] is ‘get them in, get them in a room, see the doctor’” [19]. At CGHC, intake can take up to an hour, because once again, the patient is the focus of the interaction. One volunteer explains the attitude of the clinic generally through the example of intake, saying, “this is not going to be you know like at... a regular clinic. I’m not going to manhandle you. I’m just going to ask you about how your day is going. You can say anything that you want” [1]. Intake expands the field of “relevant details” from biomedicine – giving value to what patients feel emotionally and experience socially in addition to information about physical illness. In my observation, these discussions

⁶Clinic volunteers do not use the term “holism” to refer to this philosophy. I use it as shorthand for their language. They talk about being “patient-centered” and aiming their intervention towards “the whole person.”

can reveal details important to someone’s physical health.⁷ Intake often includes discussions of mental health – which, in light of the tumult that Katrina wrought on people’s lives, is seen as a vital part of what people in Algiers cope with.⁸

The intake model was heavily influenced by the in-depth consults commonly done by herbalists. As their practice depends on recognizing broad patterns that extend through the emotional, social, and biological life of the patient, herbalists routinely spend as much as an hour with a patient. Rather than “editing out” social details, Clinic herbalists locate these details within a holistic pattern that guides their patient education and herbal formulation [3, 11].

2.2 The individual and the community – A more thoroughgoing holism

The Clinic makes an even more radical redefinition of the patient in positing a tight relationship between the community and the individual. The patient is not a “diseased body,” nor a diseased body who has social and cultural context that might effect disease state. The patient is a body in a community, whose community health and wellbeing is intimately linked to their individual health and wellbeing. In this way, redefining the patient is redefining the goal of medical care. Rather than a traditional split between “medicine” focused on the individual and “public health” focused on the community, the Clinic sees them as one and the same, needing to be intervened in simultaneously.

As a result, all Clinic interventions have an individual component and a community component. For example, a mainstay of the Model is enabling self-reliance. Self-reliance is not the idea that if people only took responsibility for their health they would get better as it might be in a traditional clinic. Instead, it is an acknowledgment that the larger system mistreats Clinic patients and inadequately equips them to live well. The aftermath of Katrina – the extent to which relief efforts abandoned low-income and minority communities – is an example of this burned into the minds of many New Orleanians. Acknowledging this state of affairs, the Clinic Model aims to assist community members in acquiring the tools they need in order to rely less on this system. It does not approach this in a way that pities residents for being inadequately prepared but, as one volunteer put it, says “you’re like really screwed and we are really sorry

⁷For example, if someone is about to be evicted from their home, or recently visited their home for the first time since the storm, that’s a likely cause of a blood pressure increase. This is more likely to be revealed during Clinic-style intake.

⁸This embracing of conversations about mental health is a stark departure from biomedicine’s treatment of mental health. Hahn writes of the internist he studies in his “portrait of an internist” – the internist says of psychiatric problems, “I’m not sure I want to get involved in that,” and “I’m not sure what all this means” [9]. Patients with psychiatric problems, like Good et al’s “socially complex” [7] patients cause him anxiety. This is because psychiatric problems are in a liminal space between “relevant” and “edit-out-able” in the construction of the patient. Hahn’s internist acknowledges that they are likely to have an effect on a patient’s physiological situation, but not in ways that can be directly observable in signs and symptoms on the body. Psychiatric problems are simultaneously relevant and irrelevant, and thus cause doctors confusion, frustration, and anxiety.

and we'd like to... be in solidarity with you" [3]. In other words, it acknowledges the harm done and works to reduce that harm in the future.

Self-reliance is fostered on the individual level through provision of free medication and connecting patients with Patient Assistance Programs (PAPs). The cost of medication is a huge financial burden – and thus an impediment to self-reliance – for a chronically ill person with no insurance. Medications for a diabetic or hypertensive person can cost hundreds of dollars per month.⁹ Therefore, the Clinic's provisions of free medications makes a significant impact on a person or family's ability to take care of themselves. Connecting patients with PAPs facilitates more long-term self-reliance. In these programs, major drug companies give free or drastically reduced price medication to people in financial need. Unfortunately, the application process is complicated and differs from drug company to drug company, so PAP benefits are not easily acquired. A clinic volunteer walks people through the application processes in the hope of finding a more long-term solution to reducing patients' medical costs [21].¹⁰

Self-reliance is additionally encouraged through helping patients transition off of unnecessary medication, which is often achieved through the integration of Western and non-Western healing. A volunteer explains "some medicines make people sicker than if they weren't taking them at all" [17]. If patients have inconsistent access to drugs, or drugs have strong side effects that are not caught because the patient cannot regularly visit a doctor, this is even more likely. Because many lost their jobs as a result of the storm, inconsistent access to medication is even more common among Algiers residents. In the Model, natural medicine, both acupuncture and herbs, help chronic disease sufferers find non-biomedical ways to manage their stress so that it doesn't exacerbate their illnesses.¹¹

The Clinic's Model strengthens pushes for individual self-reliance with interventions to foster community-level self-reliance. Just the presence of a free clinic in a neighborhood that lacked one is a step toward self-reliance, especially in light of the Clinic's aim of community control. The Model calls for instituting a community garden, herbalism class, and computer lab, all resources that if owned by the community, would promote health. The herbalism class, for example, began as a class for community members who wanted to learn how to prepare their own therapeutic herbs. Class members, including community members and Common Ground volunteers, took an abandoned lot in Algiers

⁹An example of how medical costs for a diabetic could add up: The American Diabetes Association recommends that a diabetic not using insulin would be on a minimum of four drugs a month. In the best possible scenario, the patient is on four generic drugs, their prescriptions will cost them at least sixty dollars per month. In the much more likely scenario that just one of their drugs is brand name – which might happen because they respond poorly to the generic, or they are prescribed a brand name drug and don't know there is a less expensive generic - their prescription skyrockets to hundreds of dollars per month. Add to this the cost of test strips and lancets for a glucometer – which the Clinic also gives away – and an uninsured diabetic is likely paying over two hundred dollars a month for medical expenses [23].

¹⁰The Clinic calls this their "Patient Assistance Program."

¹¹The Model calls for a variety of ways for patients to stay off their medication, but the use of natural medicine is the main ways this goal is accomplished.

and transformed it into a garden that grows fresh fruits and vegetables in addition to herbs. The class also functions at times as a support group, cooking class (learning how to use the vegetables they grow in the garden), and a weight management workshop [22, 3]. The garden and class combines traditional health education with a sustainable project in which community members became invested, resulting in resources and practices that enable Algiers residents to care for themselves.

2.3 Belief in health as structurally determined

The final way in which the Clinic redefines the patient is by redefining what makes a patient sick. Rather than biomedicine's focus on diseased cells and "patient compliance" or "behavior change," the Clinic emphasizes the role of social and economic context in perpetuating poor health.¹² They argue that poor health is structurally determined. One volunteer explains that "the general way the class system is set up in this country prevents poor folks from eating fresh vegetables which contributes to adult onset diabetes and high blood pressure" [16]. Another volunteer explains that disproportionately high levels of police harassment ratchets up the stress level of low income/minority residents, which exacerbates chronic disease [3]. Another notes that neighborhoods with few green spaces and high crime make it difficult to exercise regularly, a practice integral to good health [19]. The structural component is that low-income and minority communities are built in a way that induces poor health – with insufficient resources to enable community members to "make healthy choices."

In no place is the Clinic Model's avowal of structural determinacy more evident than in their discussion of racism. Clinic volunteers believe that through a variety of mechanisms, institutionalized racism causes and exacerbates poor health. One long-term volunteer explains "if you're a person of color whether it's here or anywhere else in America, racism is the greatest health risk you encounter" [21]. For this reason, the Clinic's intervention is suffused with attempts to combat racism. These range from Clinic volunteers validating the existence of racism when interacting with patients to working towards community control of the Clinic [17].¹³ The focus on racism shows the complexity of the Clinic's construction of "Patient." Their structural determinacy shows not only concern for poverty's effect on health, but more historical, cultural, and race-based effects as well.

¹²This doesn't mean that the Clinic ignores the germ theory of disease, or denies the efficacy of Western medical interventions to manage disease. This means that they believe that long-term, meaningful change is effected through a change of social and economic context. Structural determinacy can be juxtaposed with a "behavior change" or "personal responsibility" model of poor health. This argues that if patients changed their diets or exercised more, they could control their chronic diseases. Structural determinacy responds that low-income and minority communities are built in such a way that make buying fresh fruits and vegetables or exercising regularly largely unfeasible. The Clinic Model argues that "choices" to be healthy are beyond the means of many low-income and minority individuals.

¹³What exactly "racism" means, and why a diverse set of activities could counter racism, is the subject of Chapter 4 [of the thesis from which this paper was excerpted] [24].

Structural determinacy stems from, but also necessitates, the strong relationship between the community and the individual. In the Clinic’s Model, social change on a systemic/policy level – universal healthcare, for example – would make the most substantial impact on the health of Clinic patients, but community level change is the next best thing [18]. A need for political engagement also flows from structural determinacy – how can health be improved without an overhaul of the system that perpetuates social and economic inequality? For this reason Clinic volunteers argue that a “political push” running alongside their provision of services is necessary to improving patient health [16, 3]. Early on it became clear that they would have to choose between being outwardly political and losing their non-profit tax exempt status, or find ways to affect the community without overt politics. They chose the latter, doing so through the provision of healthcare and facilitating the growth of community voice and resources.

Structural determinacy also begs the question, if many aspects of the individual’s health status are beyond their control, what is the role of individual-oriented interventions? The answer is that in the Model, individual interventions are targeted at counteracting and validating the damage that the existing system has done on an emotional level, and ensuring that the individual’s concrete, immediate needs are met – diagnosis and treatment of illness, providing free medications, stress management, etc. Herbalists have traditionally understood the relationship between stress and hypertension, dyslipidemia, adult-onset diabetes, fatigue, chronic pain, digestive disorders, and other chronic and degenerative disorders [22]. Until the causes of stress can be removed through social action, healthcare following the Clinic’s Model can restore an ill patient’s agency and increase their ability to fight for themselves – so healthcare becomes a tool for “survival pending revolution,” as the Black Panthers phrased it [20] Finally, a strictly political approach comes in conflict with patient-centeredness. If patients say they need or want healthcare, rather than a revolution, CGHC privileges the patient’s explicit request.

In conclusion, the Clinic’s Model reconstitutes the patient – and thus subject of medical treatment – as an entirely different entity. This entity has an emotional life, and a social and cultural context as well as a biological condition, and all of these components are germane to that person’s healthcare. This individual’s health is structurally determined, and thus tightly linked to their community’s health. Implicit in this reconstitution of the patient is social change as enabling health, which is clarified as the Clinic’s Model reframes the role of a medical clinic more generally.

2.4 Self-determination for individuals and communities – the crux of solidarity

“I think when a team of people is operating in such a way that they provide one patient and then a community of patients complete right to self-determination then you are starting to experience... quality healthcare” [17].

Rather than “curing,” “treating,” or “containing” biological disease, the Clinic’s Model sees fostering self-determination as the purpose of healthcare. Self-determination has multiple layers of meaning. On one level, self-determination is akin to “empowerment.” It means creating an environment in and outside the Clinic in which patients feel comfortable and capable of making decisions about their wellbeing. This necessitates restructuring the doctor-patient interaction. Self-determination also means fostering situations for Clinic patients where their lives need not be dominated by the constraints of their poor health: where their illness does not determine them. And finally, self-determination means community control of the Clinic.

3 Restructuring the Doctor-Patient Relationship

“3. All patients and others will be treated with respect and dignity. Patients will be talked *with*, not *at* or *about* in front of them. Patients will be fully informed of their conditions to the best of their provider’s ability. Medical jargon will be explained in lay person’s terms” [2].

In the service of self-determination, and also as a component of the Clinic’s redefining of the patient, the Clinic’s Model restructures the doctor-patient relationship. It makes the relationship one of non-hierarchy, partnership, and respect.

Non-hierarchy is the key principle of anarchist philosophy, a central tenet of the Clinic’s operation, and a vital point of departure in the New Model’s doctor-patient relationship. In my observation of the Clinic’s operating, non-hierarchy means that people with more Western medical training are prohibited from treating those with less medical training in a paternalistic or condescending manner.¹⁴ The Clinic’s Model emphasizes teaching – “Everything is a learning experience” [11]. On a daily basis, doctors do not only teach medical students as in a typical clinic, but also nurses, EMTs, and patients. Furthermore, herbalists and acupuncturists teach doctors what they can treat well or better, and how psychosocial stress is impacting the patient’s physical health. Long-term volunteers teach doctors where resources are, and patients teach Clinic volunteers the dynamics of the community [15]. Implicit in this teaching is the notion that people without medical degrees have valuable forms of knowledge in the medical setting. This manifests in the Clinic’s goals of improving wellbeing of the whole person and of non-hierarchy.

In the New Model, the Clinic’s treatment of patients is not non-hierarchical. It is non-paternalistic, but it is an *inversion* rather than destruction of the hier-

¹⁴The Clinic Model does not aim for complete non-hierarchy because they fear it would be detrimental to patient care and safety. For example, a doctor’s medical diagnosis has more weight than an EMT’s. Non-hierarchy is another instance of reclaiming in which “non-hierarchy” means hierarchy among providers when patient wellbeing necessitates it, and an additional hierarchy that privileges the patient.

archy. One volunteer describes this as “putting the patient on a pedestal” [17].¹⁵ Clinic volunteers understand biomedicine as constructing a doctor-patient relationship in which the doctor is privileged, similar to the paternalistic relationship that Kleinman and Hahn describe [13]. They write that when the patient enters a traditional Clinic with a medical problem, the doctor knows how to fix it, so the doctor may speak condescendingly to the patient – suspend “normal” social conventions – if it facilitates diagnosis. In the Clinic’s Model, the interaction privileges the patient. The patient has “the *right* to be listened to for hours on end” [17], and “medical jargon *will* be explained in lay persons’ terms” [2]. The language here conveys obligation to privilege the patient and treat the patient on her terms. It requires utmost respect for the patient, and that respect structures the patient interaction.

All of the conditions serve to ideally foster a relationship where the patient “take[s] control of their own health” [1]. Their conditions are explained to them so that they have sufficient information to make decisions, and the doctor treats them respectfully, so that they feel comfortable making decisions. “Respect for the patient” draws at least in part from the herbalist contention that each person has a “vital force,” that, if sufficiently supported, is the only true healer of the body. Supporting the vital force is traditionally done through listening, health education, and herbal formulation [3, 22]. One Clinic volunteer explained “respect for the patient” in terms of being able to “hold doctors accountable” in case of a problem. She elaborated “they’re able to say to their doctor, who kind of treated them like a little bit of an asshole, ‘hey I don’t like the way you said that’ or, ‘hey have you thought about this’ and have a more direct discussion about their healthcare” [11]. Whether in confronting a problem or simply suggesting an alternative therapy, the Clinic Model aims to empower patients to raise their voice in discussion with medical providers.¹⁶

The type of doctor-patient interaction that results – one that is replicated in relationships with other providers in the Clinic as well as in the relationship between the Clinic and the community – is a complex one. It privileges the needs, desires, and voicing of desires of the patient – hearkening back to the street medic focus on consent – and emphasizes solidarity. The significance of this relationship will be examined in more depth following a discussion of community control.

3.1 Community control – community-level self-determination

“[We’ve aimed to] shape the Clinic into more than a provider of emergency services...more than a band-aid basically...[we want to become] a clinic that [is] sustainable and community-directed,

¹⁵On the Clinic floor, the process of putting the patient on a pedestal is most successfully accomplished in intake. This may be because demographically, intake providers are more likely to be immersed in the street medic/New Model discourse rather than the biomedical discourse.

¹⁶One patient recounted her appreciation for Clinic doctors, who took time to explain things and answer all her questions [26].

community-oriented and basically at the whims of the people that we're serving" [21].

The Clinic Model's commitment to self-determination through community control illustrates how the structure of the doctor-patient relationship is mapped onto the Clinic-community relationship. Once the long-term volunteers realized that a health clinic was a long-term necessity in Algiers, they expected the community to take the Clinic over, what they term "community control." One volunteer explained, "my whole deal is just to be the supportive nurse until there is someone, or a group of people who are local who are running the show" [17]. The motivation for this is threefold: the community knows how to take care of itself best, deserves resources over which it has ownership (self-reliance), and should make decisions for itself (self-determination).

Community control is also understood to be an anti-racist initiative. Many explained that a certain top-down dynamic can be created when outsiders provide services to those in need, which they code racially. A Clinic volunteer explained this type of charity: "this is the model available... the nice white folks come and give free stuff and the white people are kind of crazy... and then they leave" [8]. They see a lack of accountability and sustainability in this Model, because the white people have the ability to leave at any time, and render the community vulnerable and resource-less [21]. The antidote to this in the Model is creating a sustainable, community controlled initiative, so that the community can hold the Clinic accountable. Their concept of community control is more rigorous than Federally Qualified Health Centers' (FQHC's). They envision community control where "local community members make the major decisions regarding how the clinic functions and what services it offers," and that the clinic is "run by the community it is in" [4].

Community control as of yet, has not been attained in the Clinic. In interviews, Clinic volunteers highlighted their realization that "handing the Clinic over to the community" was a much more complex and entrenched process than they expected [11]. One volunteer explained that attaining community control "is a process. And we can look at New Orleans history and see initiatives like this where it took fifteen, twenty, thirty years to achieve some semblance of accountability" [21]. Breaking down the "charity" model requires effort, dialogue and time.¹⁷ Clinic volunteers see the difficulty compounded by the legacy of racism, which further differentiates the project of Black Panther clinics from CGHC's. While the Black Panther Party were an in-group paving the way towards community control by example, Common Ground must take what they see as an "oppressive" charity model and transform it into something that is more just.¹⁸

¹⁷Though they have not achieved community control, the Clinic works to attain it through a variety of measures: it runs community forums, pushes to have Algiers residents on the board of directors and hiring committees, and makes sure it not only knows its neighbors but that its neighbors are happy to have the clinic there [15, 28].

¹⁸The Clinic's mature understanding and racial coding of "community control" is discussed here. But understanding community control, and racism more generally, has been a process

Out-of-town Clinic volunteers see themselves as intermediaries in breaking down the charity model, in roles that are necessary in the short-term but not in the long-term. In the words of one volunteer:

So we are doing a good job of solidarity not charity, but if we were working in real solidarity we would be teaching people how to take control of their own health, which is something that needs to be taught to people. But we're only a year into this process [1].

This quote gets at the crux of how “solidarity” structures relationships in the Clinic’s Model. In the long-term, community members will be empowered to give direction to both their doctors and their Clinic, so solidarity will mean “working with” or on equal footing with outsiders.¹⁹ But until then, long-term volunteers must “teach people how to take control.” Creating conditions that make a long-term solidarity relationship possible is the fundamental puzzle the Clinic’s Model struggles with. Their solution is to engineer a relationship that combines privileging the patient/community’s needs with developing intimate relationships. One volunteer explained that they must be “intensely, lovingly involved in peoples’ lives” in order to attain the type of social change they desire and that this “is the equivalent of marriage to this city” [27]. This relationship is modeled on the relationship street medics have with each other, where you’re “working. . . with people you know in a movement you love, you’re treating your friends, your extended family, so it’s easier to give a damn” [16]. These intimate relationships preclude a top-down relationship, and are intended to pave the way for community members to feel comfortable directing the Clinic.

In keeping with the belief that community self-determination best runs the Clinic, Clinic volunteers are skeptical of their ability to make decisions about how the Clinic should be run – which is necessary in the interim before community control. As a result, they use a non-hierarchical/consensus-based decision making structure.²⁰ This facilitates reassessment and self-criticism, which volunteers believe helps to compensate for the lack of community control of the process, but does not replace a community voice. A long-term Clinic volunteer phrases it, “every decision you have to ask yourself ‘What was the input?’ We all might have the best of intentions; we want every decision to be community-

for the clinic. Chapter 4 [of the thesis this paper is drawn from] examines this process, and complicates this explanation for how racism functions in the Clinic’s intervention [24].

¹⁹“Outsiders” refers to doctors more than long-term volunteers. In the Clinic Model, the jobs of non-medically trained long-term volunteers would be assumed by community members as part of community control, as was largely the case for several weeks during the first month of the Clinic’s history. So doctors are present in a self-determining Clinic, but long-term volunteers from out-of-town are not.

²⁰The concept of “non-hierarchical decision making structure” is a compromise the clinic came to in order to balance their attempts to privilege the needs of the community, incorporate their own philosophy, and acquiesce to the requirements of running a clinic. They compromised as of August 2006 with a board of directors that includes Algiers residents and a “coordinating committee” that makes most of the Clinic’s day-to-day decisions. The coordinating committee makes decisions via consensus, which in my observation was an attempt to incorporate the principle of non-hierarchy into a structure that was more accessible to community members [21, 16].

run, but we have to be real about it: did we ask” [15]? “Decisions take twice or three times as long” when they are made in this manner, which is a problem because “the larger world does not acknowledge that we are consensus-based” [8]. Regardless, the Model requires this in order to ensure that long-term volunteers are working towards the expressed needs and desires of the community.

In summary, the relationship engineered in the Clinic’s Model between doctors and patients as well as between the Clinic and community can be characterized as solidarity in the service of self-determination. Self-determination is a re-thinking of the purpose of medical practice that is emblemized and practiced through a re-thinking of the structure of the doctor-patient relationship. Clinic long-term volunteers do not see themselves as ultimately involved in full-scale self-determination. Their role as decision-makers and lay volunteers keeping the Clinic running would be taken over by community members. But until the Clinic reaches that point, they believe that they have an obligation to engineer relationships that privilege the patient and encourage empowerment.

4 The Clinic’s Model as a discursive intervention in biomedicine and the production of health inequities

The Model’s restructuring of the patient, doctor-patient relationship/interaction and the function of medicine constitutes a substantial departure from biomedicine. Departing from biomedicine is its explicit aim. This is evident in how volunteers understand their work: the Clinic’s Model calls for “creating healthcare” rather than “practicing medicine” [17]. “Creating” is evidence of their aim to work in contrast to biomedicine, and “healthcare” illustrates their aim to do this by focusing on a more global well-being.

Biomedicine understands medicine as having a narrow purview: dealing solely with biological disease.²¹ Discursively this causes the perpetuation of health disparities, because a low-income or minority patient is understood as “unhelpable” because she is outside of medicine’s purview. Biomedicine defines the patient as a body, with social details “getting in the way.” This is part of the reason why attempts to combat health inequities within biomedicine’s discourse fall short – the patient as a subject is “unhelpable.” The Clinic’s Model intervenes in this discourse, constituting their patients as a “whole person” rather than a body, and the responsibility of the doctor is not to “cure their bodies” but to help them become self-determining whole people. This is effective for fighting health inequities because it acknowledges the social conditions that lead to poor health, and incorporates an attempt to make them more manageable.

What gives the Clinic Model the potential to intervene in health inequities is its discursive location far from biomedicine. “Patient care,” “patient-centeredness,”

²¹[The argument in this paragraph is made in Chapter 1 of the thesis from which this paper is excerpted [24].]

and “quality care for the underserved at any cost” are often part of the mission of hospitals.²² However these interventions ultimately fall short because they are located in a discourse that constructs the patient as incompatible with biomedicine. The anarchist/street medic discourse, like the Black Panther discourse, redefines both “patient” and “medicine” so that the low-income and minority individual and community not only is but *must* be served by healthcare. Street medics/anarchists demystify the biological aspect of medicine, so that it is “not that difficult” to provide. They then see social and economic change as part of the responsibility of a health clinic, and an important part of the clinical interaction. This makes possible quality care for low-income and minority patients.

This discursive shift is evident in what the Clinic monitors and sees as necessary for improvement. The Charity Healthcare System, in their mission statement, says that they aim for “high quality medical care, developing medical and clinical manpower [by teaching medical students], [and] operating efficiently and cost-effectively” [14]. In my observation, the Clinic monitors community control, how well they are meeting/responding to the community’s needs, and anti-racism. The difference between these goals is effective and efficient treatment of the body versus self-determination and holism. Cost is an obstacle to the Clinic, as in any medical environment, but the way they discuss cost – in terms of what the community most needs – is further indicative of the discursive shift.

5 A meditation on “working”

This thesis argued that the CGHC Model constitutes a discursive intervention in the production of health inequities, placing the low-income minority patient within the purview of medicine on terms of anti-racism and racial redress.²³ Is the gap in healthcare quality and health outcomes narrowing for low-income and minority Clinic patients? I walked into the Clinic wondering what it meant for them to work, and then rephrased the question in terms of whether they made a discursive intervention. In this conclusion, I will examine what that intervention adds up to.

What might “working” mean for the Clinic? In a quantitative scientific sense, it is impossible to tell whether the clinic is narrowing or eliminating health inequities yet: it is too early. Assessing this would require a longitudinal, randomized study in which patients of the same disease severity, race, and socioeconomic status were randomly assigned to receive care at CGHC versus another free health clinic. Or alternately, it would require following CGHC patients to see if their morbidity and mortality improved following the Clinic’s care. Especially because CGHC works primarily with chronic diseases, which have long arcs of observable change, the clinic has not been open long enough

²²These are all components of the Tulane University Hospital in New Orleans’ mission statement [25].

²³[For the author’s complete argument, see the complete thesis [24] – ed.]

to conduct a quantitative assessment of their project with sufficiently rigorous results.

Fortunately, there are other means for measuring the Clinic’s success. These are meaningful not only “in the interim,” but because some of the terms of the Clinic’s project (community control, self-determination, holism) cannot be assessed through quantitative measures. The Clinic’s discursive intervention away from biology-focused medicine necessitates a shift away from solely quantitative, biology-focused assessments.²⁴ What indicates that the Clinic is “working” is both quantifiable – providing a large volume of quality services – and qualitative/process oriented – developing strong relationships with the community in a way that works towards improving their wellbeing. Via both measures, there is abundant evidence that the Clinic Model is showing early signs of efficacy in fighting health inequities and facilitating community control, and that it has the potential to engineer long-term improvement in terms of the Clinic’s discursive redefinition of “health” and “healthcare.”

The sheer amount of services the Clinic has provided indicates initial success as an intervention. In one year, they provided 20,000 patient visits, hundreds of thousands of dollars²⁵ in free drugs, low-cost laboratory tests, and emergency supplies [12]. The value of their services in the first year was estimated as worth 2.3 million dollars [12].²⁶ In addition, they founded a community garden, ran an herbal class, and ran the Latino Health Outreach Project as well as the Patient Assistance Program. The fact that they remain open and seeing patients signals success at combating institutional inequities. Their efficiency at providing services – they estimate spending approximately \$200,000, all donated, in their first year – and the breadth of those services is further evidence of success [12].

The volunteers’ conception of their success and progress also provides some indication of the Clinic’s success. They couch this largely in terms of the depth of their relationships with “the community.” In minutes from a strategic planning retreat in October, CGHC outlines among their major accomplishments, “from our first day we sought out personal relationships with people in historically oppressed communities” [12]. Long-term volunteers echoed this in interviews, saying that they measured their success via the appreciation and validation of community members [15, 3, 21, 17]. One explained to me “our neighbors are so amazing and supportive” of the Clinic, and that she feels validated in her work because they are [15]. In the Clinic’s intervention, these relationships are the crucial intermediary to enabling community and patient self-determination, and thus better health. As the same volunteer put it, “it’s a process” in which these relationships are vital [15]. They are vital because they are linked to providing anti-racist, and generally better, healthcare.

It would be ideal to argue that a number of patients voiced reciprocal ap-

²⁴There are also systematized methods for measuring these things, “community level indicators” such as social capital, but the Clinic has not been around for sufficient time to measure change in these either.

²⁵ [12] cites the value of drugs donated in the first year as worth \$365,000.

²⁶The clinic received a Social Services Block Grant from the federal government, and in the process, the grantors retrospectively assessed this as the value of the Clinic’s services.

preciation, as well as the feeling that they had more control over their health. For many reasons,²⁷ I did not interview sufficient numbers of patients to make this claim. Those I did interview provided some insight into patient understandings of the Clinic “working.” One patient explained, in reference to how respectful, especially in terms of race, she found Clinic volunteers, that “they [the volunteers] are loved. Believe me, they are loved. Because if they were not, they never would have existed. . . trust me, the people in New Orleans would have run them so far [out of town]” [28]. She argues that not only are these relationships meaningful to her, but that the community as a whole would have rejected them had they been racist or paternalistic.

The depth of these relationships and the quality/quantity of their services indicate that CGHC has the potential to make a meaningful difference in Algiers’ health inequities. This raises a second question. If the Clinic’s Model works, what lessons can it teach about combating health disparities more generally?

There are some components of the Clinic’s intervention that are too situational to be exportable. Central to CGHC’s discursive intervention was the socio-historical situatedness of the street medic and anarchist founders outside of biomedicine.²⁸ Their discourse of medical practice includes an ethic of well-being, self-determination, and the demystification of medicine, which runs counter to biomedicine’s biological reductionism and professionalization. Street medic presence in the Clinic lay volunteers helped ensure the longevity of the alternative discourse, even after biomedically-trained professionals began staffing the Clinic.

The conditions of disaster further tied the specific anarchist/slash street medic discursive practices of the founders to the Clinic’s success. As one long-term volunteer explains: “we wouldn’t achieve what we’ve done [sic] if there wasn’t a hurricane” [3]. Street medics’ belief that medicine is simple and portable, plus the anarchists’ flexibility greatly contributed to the Clinic’s early success. The vacuum of government oversight that followed Katrina further contributed idiosyncratically favorable conditions. They enabled Clinic volunteers to operate according to their own Model of providing healthcare.

To this extent, the non-exportability of the Clinic’s Model illustrates how non-exportable any specific intervention is. The Model should not be understood as a template for health inequities intervention. It is possible that the Clinic’s success is due to non-discursive factors. For example, there is a level of passion, conviction and drive among Clinic long-term volunteers to make the clinic “work” on these terms that is vital to their success. As one volunteer put it, “you couldn’t pay us to do this” – the amount of emotional energy, physical energy, and time volunteers put in could only stem from conviction [22].

Some components of the Clinic’s model are exportable. Locating clinics and other resources in low-income and minority communities is one of those lessons. Another is the Clinic’s *explicit* intention of discourse shift. The Clinic’s in-

²⁷Reasons for not interviewing a substantial number of patients were explored in the introduction [of the thesis from which this paper is excerpted] [24].

²⁸[Stern argues this point in Chapter 2 of the thesis from which this paper is excerpted [24] – ed.]

tervention makes clear that in order to redress health inequities, the discourse that constructs both “patient” and the function of medicine must be shifted. Biomedicine constructs patients biologically, and the purpose of medicine narrowly as the restoration of “physiological integrity.” Because low-income and minority patients are “socially complex,” medicine categorizes them as “unhelpable.” The Clinic broadens both the subject of patients (to be more holistic) and the purview of medicine (which is to facilitate self-determination). The Clinic’s Model acknowledges that persistently inadequate provision of healthcare to low-income and minority patients is discursively rooted. They approach it with a discursive solution. Although a discursive intervention requires a specific set of historically-situated social conditions, the Clinic’s conditions are not the only ones that can produce an effective intervention, as the Black Panther clinics illustrate. Explicit discursivity – a commitment to changing medicine so that it meets the needs of low-income and minority patients, rather than changing patients so that they meet the needs of medicine, is an important and exportable lesson of the Clinic’s intervention.

The other instructive component of the Clinic’s intervention is their discursive situating of medicine as a racial project. The Clinic couches its competence in terms of anti-racism: the success of the Clinic in their Model depends on their ability to practice anti-racism. They define themselves as outsiders to the “community” – a group comprised of specific race, class, and cultural components – and oblige themselves as outsiders to be respectful, flexible, and self-conscious in order to prevent race, class, and cultural insensitivity and disrespect. Their linkage of the success of anti-racism to the success of the clinic makes medicine explicitly a racial project – a place where race dynamics are defined and resources are distributed based on those definitions. This makes the Clinic’s project a type of racial restorative justice – reconciliation and reconstruction for past racial wrongdoing. Medicine has historically been a racial project, but has denied it, so making it one explicitly engaged in an acknowledgment of harm coupled with resources that, in New Orleans particularly, takes a vital step towards a more racially just future.

The institution of medicine as a racial project differs from “cultural competence,” which makes culture just another “social detail” for a doctor to “edit out”: it makes the “socially complex” patient more complex [6]. The reconceptualization of medicine as a racial project, on the other hand, facilitates the reconceptualization of the “socially complex” patient as within medicine’s purview.²⁹ It acknowledges race as a “real” basis for discrimination in the past and present, and as a cause for differing cultural and other expectations. The acknowledgment of race as a “legitimate” factor in one’s health/wellbeing provides new meaning and justification for focusing healthcare on low-income and minority patients. It makes possible a relationship of solidarity, because it recognizes the health of low-income and minority patients as in part the result of past and present structural harm through the specific mechanism of racism.

²⁹[The argument in this paragraph is discussed in Chapter 1 of the thesis from which this paper is excerpted [24] – ed.]

This opposes a belief that low-income and minority patients are sick because they are “non-compliant” or at “high risk” behaviorally because of their own wrongdoing. It replaces the latter, which is patronizing and incompatible with solidarity, with the former, which if anything privileges the patient.

Only time will tell if the Clinic’s specific formulation of medicine as a racial project is an adaptive means for reconciling a history of racial injustice. They recently received a large grant to institute the “Community Health and Strength Project” which will combine training for patients to “make racist structures visible” in their community, with institutional support for the herbalism program’s community interventions like the community garden, and chronic disease management techniques like health education [5]. This implicates their medical intervention in creating a racially just future, and links racial justice to physical wellbeing.

Furthermore, only time will tell if the Clinic’s intervention overall will survive and be effective. Much like the Clinic’s success could be due to idiosyncratic conditions, their possible failure could be as well. Good ideas fail as community interventions every day, due to miscommunication, poor planning, and unforeseen circumstances. The Clinic’s Model, in its specific discursive intervention, its making of medicine a racial project, and its focus on solidarity, has the potential to incite long-term change. Few expected the Clinic to last as long and operate as effectively as it has. One community activist said of the Clinic that early in its history, “I thought ‘it cannot possibly continue to exist for another week or month’” because of the obstacles the Clinic faced and the amount of care they provided, but then

I started extending it after a while. The commitment and the expertise of the volunteers I’ve just never seen anything like that. . . [They have] medical expertise, community organizing expertise, the ability to fix the plumbing when it breaks [and] the ability to work with each other under really really demanding circumstances [among other things] [10].

A Clinic volunteer expressed the following feeling about their future: “just being there, it’s the only way we can prove to people [in Algiers] that we’re going to be here permanently” [15].

The Community Health and Strength Project embodies the promise of the Clinic’s Model as a response to racism as it operates in health inequities. The Project combines a critique of racism and related harmful systems with a conception of healthcare that responds directly to that critique. The result is a form of medical care that redefines the patient, doctor, and illness itself, and in so doing offers more effective, more holistic healthcare.

While Hurricane Katrina seemed to raise questions of healthcare under conditions of disaster, the Clinic’s development locates the fundamental problem of woefully inadequate healthcare in a larger social and political history of racism and inequity. By designing and practicing healthcare that addresses these issues directly, and doing so under the conditions of disaster, the Clinic stands as a testament to the possibility of transforming racism and inequality in healthcare and

beyond. What is perhaps most inspiring about the Clinic is not the particular Model it devised and the practices it put into place, but rather the willingness to find out what they did not know about the community they wished to serve, and to incorporate this into their Model. The task for those who follow will not be to use the Clinic as a template, but to devise their own way of identifying and responding to the conditions that they find on the ground, without ever “editing out” the realities of injustice.

Definitions

Discourse and Discursive Interventions

“Discourse is useful for studying the Clinic and their Model because it offers a theory of (social) power in which practices and words are constitutive of the world. To take discourse as the object of an ethnographic study of the Clinic’s Model is to consider how practices, policies, acts and words work together to define and address the issue of health and healthcare; and whether this ‘making’ of health and healthcare constitutes an effective transformation of traditional biomedicine. . . . From a Foucauldian point of view. . . the capacities, behaviors, and manners of speaking of individuals are formed through the workings of power; they are its effects, not its causes.

“Discourse constrains what can and cannot be said [and] discursive practices [are] the components that make up a discourse. . . . One must examine language, practices, and writing to understand how a discourse operates. Therefore, in studying the Clinic’s discourse, I drew from an array of sources: participant observation (to study its practices), interviews (to study its language), and documents (to study its writing)” [24].

Common Ground Health Clinic

Common Ground Health Clinic was founded on September 9, 2005, less than two weeks after Hurricane Katrina, in the Algiers neighborhood of New Orleans. It was hastily conceived in conversations between a small group of street medic/anarchists from out of town and a small group of neighborhood community leaders and community activists who remained in Algiers through the storm, including a former Black Panther. Common Ground Health Clinic offered the only medical services available in the City of New Orleans for weeks after its founding. In its first year, it provided healthcare to 20,000 patients, making it one of the highest volume free clinics in the United States.

“In July [of 2006, when this study was conducted], the Clinic was open four days a week, staffed mostly by local doctors and long-term volunteers, with a few short-term doctors and nurses cycling through. They had four paid staff: two part-time volunteer coordinators, a nurse practitioner, and an executive director. They offered Western primary care, including low-cost laboratory tests (the only thing the clinic charged for, and no one was denied labs for inability to pay), herbalism and acupuncture, and intermittent social work. They gave away free medications when they had them, free preventative supplies like glucometers and test strips, and helped patients sign up for free medication through the ‘Patient Assistance’ programs of drug companies. The Clinic also operated a bilingual satellite clinic on the East Bank for migrant workers, though at that time it ran intermittently. From opening until closing, the Clinic was almost always swamped with patients. The Clinic also helped maintain a community garden that their herbalists had helped found. To give a sense of the size of the Clinic on any given day, Clinic staff included two people at the front desk, two or

three intake providers, a doctor, a nurse practitioner, two medical students, at least one non-Western provider, and one or two long-term non-medically trained volunteers to ensure that everything ran smoothly.

“Clinic patients were generally uninsured. The Clinic saw more women than men, and mostly adults. Most patients were African American, and the rest were Latino, white and Asian. Almost all the patients were from New Orleans, mostly the West Bank, although about once a day an injured out-of-town relief worker would seek care. Residents primarily sought the Clinic’s care for chronic disease management – diabetes mellitus, hypertension (high blood pressure), hyperlipidemia (high cholesterol), etc – and vaccinations” [24].

The Latino Health Outreach Project

“Early in the Clinic’s history, they noticed the beginnings of a major demographic shift in the city. After President Bush suspended the federal minimum-wage law, migrant workers, almost uniformly Latino, were bussed into New Orleans to do cleanup and rebuilding work. CGHC volunteers recognized that these people were almost uniformly uninsured and sometimes undocumented – meaning unlikely access to healthcare. And they more than anyone would need vaccination and treatment for chemical exposure due to their work in toxic floodwater. So the Clinic set up the Latino Health Outreach Project (LHOP), a street clinic. Initially it ran a few days a week, but when I arrived at the Clinic, they had insufficient resources to operate it more than twice a month” [24].

Street Medics

“Street medics are defined as people who provide medical support at protests and demonstrations. They have varying levels of medical training from Wilderness First Responders up through physicians – though most have the skills of EMTs with some supplemental knowledge of herbalism. They are “basically radical activist medical professionals.” Contemporary street medics identify as anarchists, even more as “radicals” though being an anarchist or a radical is not a prerequisite. Street medics trace their lineage back to the Civil Rights Movement” [24].

Long-Term Volunteers

“Long-term volunteers – almost all of them some combination of street medics, anarchists, and people sympathetic to anarchist philosophy – are the Clinic’s analogue of the Black Panther Party lay volunteers, and just as essential to maintaining the alterity of the Clinic’s discourse. They are sentinels of the alternative discourse, and enforce it in the Clinic’s space. In the Clinic, long-term volunteers are central to the long-term planning process. This is both because of their longevity – they provide institutional memory for the Clinic – and because they have sufficient time to devote to strategic planning. Their influence means they can ensure that the alternative discourse is maintained.

“The Clinic emphasizes community input and community control in their long-term planning process, which would imply that long-term volunteers should not entirely set the course of the Clinic. But at the time my research was conducted, the Clinic was still mostly staffed and run by outsiders/long-term volunteers. Furthermore, many community members and local doctors did not have sufficient time to devote to the strategic planning process. So the discourse practiced among the “outsider” long-term volunteers enforced their alternative to the biomedical and it was practiced and incorporated in the Clinic. While community members had space to provide input about the direction of the Clinic and ideally will have control of the Clinic in the future, the street medic/anarchist philosophy still held primary influence as a discursive practice” [24].

References

- [1] Roger Benham. Interview by author, 8-12 2006.
- [2] Roger Benham and Jenifer Whitney. Common Ground Clinic “operating rules”, 2005.
- [3] Katya Chizhayeva. Interview by author, 8-1 2006.
- [4] Common Ground Health Clinic. Common Ground Health Clinic volunteer orientation handbook, last updated 7-23 2006.
- [5] Common Ground Health Clinic. Recovery grant awarded to health organizations serving hurricane effected communities. http://cghc.org/1_07pressrelease.html, accessed 3-12 2007.
- [6] Byron Good. *Medicine, Rationality and Experience*. Cambridge University Press, Cambridge, 1994.
- [7] Mary-Jo Good, Byron Good, Cara James, and Anne Becker. The culture of medicine and racial, ethnic, and class disparities in health care. In Institute of Medicine, editor, *Unequal Treatment*. Institute of Medicine, Washington, DC, 2003.
- [8] Greg Griffiths. Interview by author, 8-14 2006.
- [9] Robert A. Hahn. “Treat the patient, not the lab” Internal medicine and the concept of ‘person’. *Culture, Medicine, and Psychiatry*, 6(2):219–236, 1982.
- [10] Sharon Johnson. Interview by author, 8-18 2006.
- [11] Grace Keller. Interview by author, 8-1 2006.
- [12] Grace Keller. Notes from first Common Ground Health Clinic strategic planning retreat (October 2006). Posted on street medic wiki: http://medic.wikia.com/wiki/2005-2006_Common_Ground_Health_Clinic_-LA#Some_of_our_accomplishments, accessed 3-11 2007.
- [13] Arthur Kleinman and Robert Hahn. Biomedical practice and anthropological theory: Framework and directions. *Annual Review of Anthropology*, 12:305–333, 1983.
- [14] Louisiana State University “Charity” hospital. Mission statement. http://www.lsuhs hospitals.org/About_LSU_HCS D/mission.htm, accessed 3-8 2006.
- [15] Gina Lutz. Interview by author, 8-17 2006.
- [16] Noah Morris. Interview by author, 8-10 2006.
- [17] Anne Mullé, FNP. Interview by author, 8-15 2006.

- [18] Colleen Murphy. Interview by author, 8-19 2006.
- [19] Adi Nadimpalli, MD. Interview by author, 8-11 2006.
- [20] Alondra Nelson. *Black Power, Biomedicine, and The Politics of Knowledge*. PhD dissertation, New York University, 2003.
- [21] Steve Peace. Interview by author, 8-12 2006.
- [22] Rachel Reeves. Interview by author, 7-31 2006.
- [23] Medical information provided by Dr. Janice Spinner, MD, Internal Medicine Specialist.
- [24] Rachel Judith Stern. “This is solidarity,” not biomedicine: The Common Ground Health Clinic and discursive intervention in racial and ethnic health inequities. BA thesis, Harvard College, Social Studies Department, March 2007.
- [25] Tulane University Hospital (New Orleans). Mission statement. <http://www.tulanemedicine.com/>, accessed 3-8 2006.
- [26] “Wanda” [pseud.]. Interview by author, 8-18 2006.
- [27] Jenifer Whitney. Interview by author, 8-7 and 8-8 2006.
- [28] Lannette Williams. Interview by author, 8-17 2006.

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