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## **TUFTS-DELTA HEALTH CENTER AS A TEACHING INSTITUTION\***

JAMES R. EVERETT, M'70

I was in Mound Bayou in the summer of 1968 along with five other students from Tufts on a fellowship from the Department of Psychiatry. Each had his own reasons for going to Mississippi. For some, it may have been a desire to participate in the organization of a community health program, or the desire to spend a productive summer learning something about life and people which they could never learn in Boston or in the traditional medical school setting, or a desire to learn first hand about the problem of racism in the rural South and by extension in America, or a desire to contribute in even a small way to rectifying a very serious social problem in America. Certainly for me and the others, the motivations were many.

The university medical school, whether it be Tufts or another, has three major functions—to provide service, to teach, and to do research. Tufts University has a tradition of excellence in all three of these areas in Boston. It is the stated policy of the University that the Tufts-Delta Health Center attain the same excellence as the Boston Tufts community in services, research, and teaching. In fact, the Health Center in Mound Bayou is not beyond the walls; it is an extension of the walls.

In the summer of 1968, the Health Center had been open to serve the population for about nine months. The staff, which was limited at that time, was not in a position to devote equal energies to all three areas. Created as a vehicle for social change, and interested in the establishment of roots in the community, the staff's concern was for the organization and delivery of medical and paramedical services to the community. There was neither the desire nor the will on the part of most of the staff to be involved in preceptorship or teaching programs for students. There was very little in the way of a concrete educational program when I went to Mound Bayou. We all were left pretty much to fend for ourselves.

The summer of 1968 was, however, a period of tremendous dynamism, innovation, experimentation, and decision-making on the part of the staff. It provided the students with a unique opportunity. I participated in the growing pains and the development of a comprehensive health care center. The problems and thrusts of the people at the Delta Health Center were many. For example, there were problems with staff organization and communication among members of the staff; there was the necessity of first gleaning some understanding of the community, of communicating with it, and of trying to meet its needs. It became obvious that the comprehensiveness of the program was such that the delivery of medical services became a very small part of the overall thrust of the program.

In fact the situation worked to my advantage because it forced me out of the Health Center and into the community. It minimized my medical experience but maximized my exposure to other aspects of community health care. I was assigned five patients as index cases who came to the Health Center for medical treatment. I then visited them in their homes two to three times a week and at the end of eight weeks wrote a family case study on each of the families. In acting as the liaison with the Health Center for these families, I had to consult with and work with the paramedical departments. For example, I worked with social service to make sure that a family with a sick child had enough milk for the week. After a child had been bitten by a rat while asleep, I worked with the sanitation department as they put rat poison out at the nearby dump and put new screens on the windows and doors. I worked with the Public Health nurses who would make home visits to make sure that the chronic care patients were taking their medicine properly. I learned that the interrelationships between the environment, the individual and his disease are many and complex. I learned that you can not completely understand one

\*Presented at Tufts Medical Reunion Days, May 10, 1970, Hyannis, Mass.

without understanding the others. I learned that you can not treat one without treating the others.

In Mississippi, poor people do not go to see doctors when they are sick, perhaps because they have not been educated as to what are the signs and symptoms of illness, or because they do not have transportation to the doctor, or because their supply of money is limited and must be used for children's food. If one of the older children in the family becomes sick, the family may go hungry for a week. In the Delta, when a child becomes twelve years old, he works ten hours a day picking cotton to help feed his family. If he is sick and earns no money, the family may not have any food. Children in Mississippi have chronic hookworm infections, not because they do not like to wear shoes, which they do not, but because they do not own any shoes. I have used examples from my experience in Mississippi but I think that my impressions of the problems can be generalized to include all areas of the United States, from the ghettos of Boston and Harlem to the rural areas of northern Maine, New Hampshire, and Vermont. The point is the problems are tremendously complex. The solutions involve not only a curing of the immediate disease; they involve the improvement of the quality of life. Physicians alone can not do the job. A multidisciplinary approach, as is being attempted at the Tufts-Delta Health Center, is necessary if we are going to improve the standards of health care for all of our people. Having spent two months in Mississippi, I am more aware of our health and social problems, and I do not think that we can separate the two. I have a sober understanding of the difficulty in finding solutions, but most importantly I recognize the importance and urgency in working toward a total and comprehensive health care system for all of our people.

In the past, Medical school education has been dominated by a blind orientation to the university hospital as the only proper setting for acquisition of skills and treatment of disease. Totally lacking from medical education is concern for the quality of man's life and for the total well-being of the patient. A physician can not treat a disease

and ignore the environmental and cultural background of the individual. Hookworm in Mississippi is not a disease; it is a syndrome. Lead poisoning in Boston is not a disease; it is a syndrome. You can not treat a 7 year old boy for acute lead poisoning and send him back to his dilapidated ghetto housing and do nothing to try to change his environment and say that you have practiced good medicine. Some people may say that it is not necessarily the concern of the physician. I submit that it is the concern of the physician because it relates directly to the total care of the patient.

Living and working in Mississippi, even for a short time, brings all of these issues into sharp focus. As an educational experience, it is a medical one in the broadest sense, which is as it should be. It dramatizes the need and the urgency to find a better and more comprehensive way to meet the health needs of our people.

As a conclusion to my talk, I would like to list 6 precepts which the students from the summer of 1968 felt should be the goals of an optimal experience in community medicine. The five students outlined these goals just after our return from Mound Bayou.

(1) "Insight into the social dynamics of the target community with knowledge of the social priorities of the target population and understanding of how the community defines good health. Of concern should be possible means for absorption of the health center by the community.

(2) "Knowledge of the role of environmental health in medicine with a dual understanding of the effects of the environment on the relation between the individual and his disease, and the burdens of disease on the relation between the individual and his environment.

(3) "Understanding of the epidemiological patterns of disease in the community and the implications of preventive efforts.

(4) "A concept of roles involved in a health care team and the role of the health care team in the community. Included would be an understanding of the functions of social work in relation to the dynamics of the individual family.

(Continued on page 42)



## Theater Award To Dr. & Mrs. Salvatore Sannella

Salvatore Sannella, M'18, and his wife of Springfield, Mass., were given the 1970 Rose Kamberg Citation given by the American National Theater and Academy, for their outstanding contributions to the theater as members of the audience.

It was the first time a national theater organization gave formal recognition to members of the audience rather than participants in the theater. The couple has been in the audience as regular patrons in almost every theater project in the Connecticut Valley as well as having attended theater functions during their national and international travels.

The Citation to Dr. and Mrs. Sannella reads: "The audience is an important, integral component of the living theater. It is time for proper recognition of those people who make up the observer portion of the theater experience. Like those on stage or behind the scenes they share in the performing art as equal partners".

"Because of their efforts in behalf of the performing arts as dedicated members of the audience, encouraging new ventures, and propagating greater audience development through their very presence at such events, we salute Dr. and Mrs. Salvatore Sannella as being true patrons and participants in the cultural growth of our community and our nation."

(Continued from page 30)—Everett

(5) "The continuing search for the most effective design for the delivery of health services to the community, including insight into the practice of clinical medicine outside of the hospital; orientation of medical care away from crisis treatment to preventive treatment; the meaning of sustained child care; the problems and methods of family planning; and an understanding of the components and therapeutics in community mental health.

(6) "Knowledge of the socio-political in-community, but beyond community control.\*"

\*J. Brem, J. Everett, J. Koster, T. Sacks, L. Schwartz, Education in Community Medicine, July-August 1968.

## Fernando Biguria, M.D. Former Tufts Professor of Medicine

Dr. Fernando Biguria, age 67, long time teacher of medicine and Director of the Tufts Medical Service at Boston City Hospital, died June 18, 1970 in his native Guatemala. Dr. Biguria graduated from the Facultad de Ciencias Medicas da la Universidad de San Carlos Guatemala in 1929 and became a teaching assistant at Tufts in 1930. He had various titles since then such as lecturer in physiology, research fellow, Charlton fellow, instructor in medicine, assistant professor, clinical professor and finally Professor in Medicine from 1958-1968 when he was made Professor Emeritus July 1, 1968. He was most regarded for his ability as a teacher in medicine. He leaves his wife, a brother and two sisters all in Guatemala. Address: 1 Avenida 12-21, Z-10, Guatemala City, Guatemala.

(Continued from page 24)—Goldman

The body of circumstantial evidence linking EBV with Burkitt's lymphoma does not prove an etiologic association but it is suggestive. It may be that EBV acts in collusion with a presently unidentified environmental or genetic factor; Burkitt has suggested that chronic stimulation of the reticulo-endothelial system by latent malarial infection may be such a co-factor. It appears at present that EBV stands a good chance of becoming the first proven oncogenic virus in man; but should it turn out to be an innocent passenger, the techniques developed in its study will contribute substantially to the investigation of all future oncogenic viruses.

This is publication No. 1377 of the Cancer Commission of Harvard University.

Tufts Medical Alumni Bulletin

Edna F. Easter, retirement spending and summers in Mas

Morris Hoffman, E he and Mrs. Hoffma golden wedding ar daughter, Ellen G. from Jackson last and is now taking h University in Wash Ellen was elected to

Joseph H. Carey. in May, 1970 after Dispensary of the P He had practiced p Dorchester, Mass, a siology at St. Mar chester and on the st

Karl T. Phillips, he enjoyed meeting s last fall. Dr. Phill retired in 1962, he member of the Com until last October, v on the Board for 3 times a year at the S recommends that ho is in active practice jig saw puzzles, doi taking lessons in oil

Edward J. Lamb, retired from active p Frederick M. Lee, that he was with th when he retired.

William R. Carso the practice of radi

Charles J. Ashwo retired after forty surgery.

Francis J. Tarsney has retired from act Lawrence R. Dame that "giving up su calmer."

Morris L. Grover, retired from servic Health Department a the Santa Rosa Hos Robert C. Lavrak is a full time consu tional Rehabilitation Department at the position he has he since 1947.

Edward O. Brode Vice-President of th Medical Society, pl Med. Soc. Committe

June, 1970