Cohen

November 27, 1967

The Honorable Wilbur Cohen
Assistant Secretary
Education & Welfare
Washington, D. C.

Dear Mr. Cohen:

As a memorandum of our telephone conversation on Wednesday, November 22, 1967, and to further identify the program as I have conceived of it, I wish to submit the following:

Proposal of new office:

Deputy Assistant Surgeon General of the USPHS "for urban health relations".

(A) Function & Purpose:
To prepare, motivate and communicate in more meaningful ways with the broad-based health consumers, especially in core areas of urban centers often referred to as big city ghettos. The urban poor, while not the only needful segment of American citizens healthwise, constitute statistically the great bulk of those who suffer from health care needs. The health care needs of these people are further magnified by great population density, poor housing, and all the social and psychological problems of poverty, underemployment, and geographic containment. Because of all these areas of long-existant depravity, these population areas are subject to certain social explosiveness in our time which certain new, aggressive and forthright approaches in the health field, in my considered judgement, would assist in appeasing, controlling and preventing.

In all of my years of being involved in the health problems of the urban poor as a voluntary worker, while primarily involved in teaching, research and the practice of internal medicine, I have noticed one great shortcoming which seems to be glaringly present in the voluminous new health plans. It is the failure to give major though and effort to preparing, motivating and communicating in more meaningful ways through mutual education with the broad-based health consummers. The urban poor are ripe for overt resentment for years of disease stereotyping (which has often determined the direction of dade), and for receiving their good care through the expediency of clinical material while assuming that they have been blind and ignorant to the role assigned them. The people concerned are not limited to a single racial or ethnic group.

There is great need for a continuing mechanism of education for acceptance of disease prevention practices and therapeutic procedures as well. The latter includes education for acceptance of physical and psychological rehabilitation of ghettorized young and middle aged adults. Communicating in more meaningful ways with the broad-based health consumers would also include involvement of these people in identifying health needs. What do they think they need? This may be determined by questionnaire and other methods. A forum mechanism may very well result in a two-way educative experience in identifying and in planning the delivery of direct and indirect medical services. Parenthetically "delivery of medical services" is a well established but probably unfortunate expression because it at once suggests a one-way process.

Peo People at the grass roots should be more involved at the policy-making level of planning how, where and by whom medical services may be carried out. People with health related skills among medically deprived population groups should be utilized and those with potential skills should be motivated to accept training and development. The people themselves should be more involved in talent scouting among their peers.

Without going into further detail as to possible areas of communicating more meaningfully, lets discuss briefly,

(B) Methodology:
A special staff organized as an adjunct to the surgeon general's office under the direction of a deputy Assistant Surgeon General for Urban Health Relations would interact with officials of local voluntary health agencies and representatives of their members and clients to carry out the aims briefly described above and others to be developed by planning within the same frame of reference.

Members of the special staff of "Urban Health Relations" would also interact with local officials and staff of other ongoing P.H.S. programs with special reference to Regional Medical Programs (P.L. 89-239) and Comprehensive Health Planning (P.L. 89-749). These two programs should lend themselves readily to the development of a cooperative auxilliary program which would be supportive of the major thrust of the intent of P. L. 89-239 and P.L. 89-749, especially since all would be relatively new and unintrenched with procedural methods.

The local staffs of Urban Health Relations would lay down the "softening-up barrage" in the community to make more effective the community involvement of Regional Medical Programs.

In many places, especially in large urban medical centers with more than one medical school, there would be considerable difficulty for the medical hierachy of these centers to relate not only to each other but to the broad community in terms other than those which extol the long established philosophy of the noblese oblige. Yet in my considered judgement, and I think that of others who have studied and have experienced the problem, that unless an innovative and effective break-through is made at this level so that medical center leaders can see and accept a common ground relationship with community

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professionals and community leaders in their respective districts, the main thrust of the intent of Regional Medical Programs and Comprehensive Health Care Planning may fall considerably short of investment demands.

The staffs of Urban Health Relations should have the training and stature, and would have the authority to bring to the medical center coordinators and directors of Regional Medical Programs the thinking and desires of community professionals and leaders and health consummars in the new and broader and more effective extension of medical care. Reciprocally the needs, the requirements and points of view of medical center professionals may be more understandable and more acceptable to community professionals and leaders and health consumers through intermediaries whose especially developed talents are seeing both sides of the difficulty problems and helping to establish common grounds. The Urban Health Relation staff would develop techniques and sewve as such intermediaries.

In many big cities there are scores of physicians taking care of the poor and the not-so-poor who have nohospital connections. Scores of others work in proprietary or non-teaching hospitals whose diagnostic and therapeutic procedures average five or more years behind the scientific advances practiced in the teaching hospitalsaand medical school centers. Most of these have tried and failed to break through to meaningful involvement in the better equipped and advanced teaching hospitals. The staff for Urban Health Relations would also assume the following very important tasks:

> To identify and remotivate these practitioners and intercede for them individually for more meaningful "flesh and blood" involvement at medical school centers and top-level teaching hospitals, using "selective referral", extended courtesy-staff-with-consultant techniques; to negotiate policy decisions in these areas with hospital executives and Regional Medical Programs coordinators.

BRIEF OUTLINE OF PROPOSED ORGANIZATION STRUCTURE:

Executive Office of Deputy Assistant Surgeon General for Urban Health Relation adjacent to that of Surgeon General at Bethesda.

Operations Office for Planning and Development to be located in Chicago, Illinois where the Deputy Assistant Surgeon General would develop the program for the next few years periodically communicating to the Bethesda office.

From this office a demonstration or pilot project would be concentrated in the Illinois region of Regional Medical Programs against heart disease, cancer, stroke and related disorders. The Planning and Development staff would devise plan and test out techniques with public relations advisors, health educators, psychology and medical sociology and statistics related personel and set up criteria for continuing self-evaluation of the program. Other methodology functions of this office to be further planned.

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Other strategically selected regions of the Regional Medical Program and comprehensive planning areas would be the focus of pkanning development from the operations office in Chicago, Illinois within a few months after beginning of development of a planning phase in the Illinois region.

Overall planning for the auxillary program of Urban Health Relations would be set at a preliminary period of three years.

Operations phase of the program would be set to begin within 6 months to 1 year after beginning the planning process and to extend for a preliminary period of three years making the introductively effort extend to an estimated 4 years, covdring the suggested appointent period of the Deputy Assistant Surgeon General for Urban Health affairs.

Suggested preliminary staff and budgetary matters which hopefully could be designated from already appropriated administrative funds would be considered at a later date.

I hope that this statement which can be further clarified may interest you and have some possibility of being instituted in the not too distant future for mAny reasons.

Under separate cover a packet of pertinant information.

Sincerely and respectively yours,

Leonidas H. Berry, M.D., F.A.C.P.

LHB:edn