START OF TAPE 1, SIDE A

EVELYN SCHMIDT
FEBRUARY 9, 1999

ANN KAPLAN: OK. This is Ann Kaplan speaking with Dr. Evelyn Schmidt, the executive director of Lincoln Health Center in Durham, North Carolina, and today is February 9th, 1999, and we're in Dr. Schmidt's office in the health center. Hello. [Laughter.] I always feel like I have to do that little radio personality thing at the beginning. So, could you tell me when and where you were born?

EVELYN SCHMIDT: Actually I was born in New York City, but very briefly, and I really mean very briefly, because we moved to New Jersey, where I was raised. So I really consider New Jersey my home.

AK: And how long did you live in New Jersey?

ES: Well, until I went to college. And like everything else, after that, you never really go home again, although home is still where you were raised.

AK: And what did your parents do?

ES: My mother was a homemaker, who actually worked though with my father in business in later years. And my father was an engineer and also had a law degree.

AK: And so then where did you go to school when you left home?

ES: Well, actually I went to Duke University, both undergraduate and medical school.

AK: OK, OK. So you came right from that age, at eighteen?

ES: Sixteen, seventeen, in that area, which is interesting because I'd never been south, and it was my really first experience. I must say I got an excellent education, but I did not go along with the political philosophy of the South. So when I left, I thought, hail

and farewell. Thank you for the education, but I'm not coming back. At that time it was still very much a segregated society.

AK: So that's what you mean by the political philosophy?

ES: Yes. That was not my politics.

AK: The politics of race.

ES: Right.

AK: And how would you characterize your politics at the time and then later?

ES: Well, let's put it this way, and I'll characterize it right now. I consider myself the last of the FDR Liberals.

AK: [Laughs.] OK.

ES: And I still think some of the things that Franklin Roosevelt said back in the late 20s, early 30s, and in his presidency, we are still trying to do, and that is to provide and make sure that all people have health care, education, and a decent place to live. And he made that statement in 1929 when he said, "No nation can succeed when one-third of the people are ill fed, ill housed, uneducated, and not receiving health care." And although we've made some progress, we still have a ways to go.

AK: Let me ask you a quick question sort of as an aside, a tangent. Did you grow up in your household with your parents having that sort of idea there?

ES: Yes, yes. I grew up in a very progressive-thinking household, where all people were shown respect and appreciated.

AK: So your family had many friends from different backgrounds?

ES: That's right, yes. Very much, I realize now. Although as you grow up, you're always disagreeing with your parents about something. [Laughs.] I actually say

now, because I remember particularly my father. He would prompt me. He would deliberately take the opposite view just to make me think, to defend what viewpoint I had. And like so many teenagers, I really would get so obnoxious. "How can you be so stupid?" And then realized much later in life that it forced me to try to defend what I was saying realistically.

AK: And so you felt when you came to the South that the politics in North Carolina were at odds?

ES: Exactly. When I came down, I was very interested in going on to graduate school, so no. I had tough courses and so you never really were aware of what was happening until you got into the community or took a bus or something like that. Then you suddenly realize what was really happening, or what wasn't happening. Let's put it that way. And I remember when I was in medical school, my brother was going to Rutgers University at that time, and I remember distinctly he sent me down the local paper and one of his friends, who was a young African-American fellow, was voted president of the senior class at Rutgers. And he writes, "This wouldn't happen where you are." He was always sort of jiving me a little bit about being in the South.

I met some very nice people. Now, putting aside the politics, I met some very, very fine people, and really many of my classmates that I became very friendly with were actually from the South. I laughingly said many of them were very good writers, and now I know why so many good writers come from the South. They are very oppressed, right? But basically, again, you sort of have to differentiate how people were raised and what their climate was. Many of them differed very much with the political philosophy

of the South, which gave me always hope in the sense that there were young people who did not think it was appropriate.

So it was just interesting being able to discuss openly political things that came up. As I said, I just depends on where you were raised, how you were raised, and whether you then develop some independence of thinking. We don't have independence of thinking today in all areas, as you know. So in that sense we still have a long way to go when you look at the issues that are preventing us from providing health, education, decent housing, and choice of what one wants to do.

AK: Just from the perspective of researchers who might listen to this, could you put those years when you were at Duke in a particular time? What years were those?

ES: I was at Duke from '43 to '51.

AK: And when you said things that were happening and things that weren't happening in the climate of the South, the climate of North Carolina--?

ES: Getting reference to where we're moving to, basically what you saw was either you were born in the South or Northerners who had migrated down to the South. I laughingly said that the only languages you really heard was English.

AK: What did you say?

ES: Well, when I came back down again--. But even as a younger person, coming to school for the first time, what you heard was English with different dialects, because not all Southerners have the same dialect, believe me. Depending where they came from, where they were raised, you had great variation even in your Southern dialect, or intonation if you want to call it, rather than dialect.

AK: And being at Duke for your undergraduate and medical school, did you have a lot of interaction with the Durham community? Did you find mostly you were on campus?

ES: Most of your activities are really confined to campus, because very honestly--I'm going back there before your time--there were no such things as cars. You were very much restricted in terms of bicycles. If you had anything at all, the bus. I can remember twice, once in undergraduate and once in medical school, Marion Anderson who was a great opera singer of the time, came down and sang over at B.N. Duke Auditorium. She didn't sing in Page Auditorium. And I remember going over to B.N. Duke Auditorium and saying, "Why isn't she singing at Page Auditorium?" And it was episodes like that that sort of made me realize.

And then I realized when I got over to B.N. Duke Auditorium, two-thirds of the people over in Duke Auditorium came from Duke. B.N. Duke Auditorium, on Central's campus. So there were times, yes. Most of your life was confined, I must say. Where it was interesting, again, because we had some very good discussions, and particularly in theory, you know, talking about all issues, political issues, non-political issues, etc. But basically you were very much confined, more or less, to the campus, to the activities that were carried on there.

AK: So then, in undergraduate, what was your course of study?

ES: Oh, as an undergraduate I had a double major in chemistry and zoology, but knowing I wanted to go to medical school, basically.

AK: So then you did your work in medical school. And then what was your path?

ES: Well, then I went on and got training in pediatrics and I did my residencies, and that was scattered over the country. Also, some years after that, got my masters in public health at Columbia University in New York. And for a brief period, I was in private pediatric practice and then went back into, more or less, public sector. I was really very concerned because where I practiced was what I would call a blue collar working town.

AK: And where was that?

ES: In Pennsylvania. And so, it bothered me, being the newest doctor in town, on Wednesday afternoon sometimes they would say, "Will you take emergency calls?" because I would still do house calls, where that was the afternoon where the other doctors were quote-unquote off to the golf course. And so some of the homes that I went in to make emergency calls, the problems these youngsters were facing were not just the acute problem that I was called for.

And these were very honorable people. They didn't want to call you unless they had a few dollars to pay you, and consequently there was a lot of unmet health needs that you saw. And I kept thinking, "We can do better than this as a nation, especially for our children." I was a pediatrician. So I sort of wandered into the public sector.

AK: And then what years were that that you were doing your private practice?

ES: Well, I had a fellowship for a year in pediatric cardiology and then came back and was working in New York City in a hospital full time and then went to work for the New York City Health Department. And that was another exposure to the youngsters, and I was in the division of chronic disease. Then I began working in health centers in New York City and eventually came down here. And at times the government would

fund programs which enabled you to do the kind of care for kids that you would like to do. We had a Children and Youth Program at one point in time which was an excellent model of the kind of comprehensive health care kids should be entitled to, which included not just medical but social supports and things that are necessary.

AK: What kind of social supports?

ES: Your team was not just a doctor. Your team included a social worker, and you had the kind of playroom activities that really promoted development and education for the youngster, but also for the parent. Then it was the kind of model program you loved, but that you would like to see all kids have. And eventually federal funding was returned to the state, and in most states, the program dissolved.

AK: And when was that program?

ES: It was in the mid- to late-60s and 70s.

AK: And that model had a name?

ES: It was called Children and Youth Program. And they had several programs in New York City and all over the country. What we talk about, but sometimes don't particularly fund adequately, is what does it really take to maximize development in not just medical but social health and family support.

AK: So then, your time in Pennsylvania, that was before you went to New York City?

ES: That was before New York City. Then I came down here. As I said, when I came down here, you were coming down to a community which was really, again, more advanced. We know that segregation legislation had been passed, although initially when we opened the health center here, which at that time occupied the ground level of the old

Lincoln Hospital, which is really where the parking lot is. And that had been in the community since the turn of the century. It dates back to when Dr. Aaron Moore, who was the first African-American Board-certified physician to come to Durham--. At about the same time the Duke family was planning to put up a statue to tobacco workers or Confederate soldiers. I never quite got the story straight. Anyhow, Dr. Moore convinced them that the money would be better spent for a hospital.

So the first Lincoln Hospital was actually a wooden structure on Proctor Street that burned down, and Dr. Moore went about raising the moneys for the hospital that we tore down. Unfortunately he died about a year before the hospital opened. You see, at that time we had Lincoln Hospital, which served primarily the African-American community, and Watts Hospital, which served the white Durham community. And about the same time that we opened up, which was mid-September, 1971, the Lincoln Hospital board of trustees had received a grant from the federal government, which at that time was funding, at first, neighborhood health centers, under the Office of Economic Opportunity, and then community health centers under the Public Health Service Act, which had been amended.

So basically, we came into being at the same time that Durham County Hospital Corporation came into existence in order to build the new hospital, which was an amalgamation of Lincoln and Watts. And as you know, it was known at that time as Durham County Hospital, now Durham Regional Hospital, and that hospital opened up in October of '76, at which time Lincoln and Watts both closed as in-patient facilities. And the health center then occupied all four floors of the old building. Part of the requirements of the grant was that the board of trustees of Lincoln Hospital had funded a

community board, which really was responsible for administrative policy. And the community board is largely, actually, users of the center, and then those institutions which really the center works with.

Now when the new hospital opened up, the fiscal grant passed over to the Durham County Hospital Corporation, but the community board and all of its responsibilities stayed in place. So basically, we then occupied all four floors of a very tired old building, and the president of Durham County Hospital Corporation at that time, Mr. Tom Harrington, and I agreed that what we needed was a facility that would accommodate an ambulatory program, not an in-patient. But with a tired old building, whose elevator didn't always work and you couldn't always have air conditioning and light at the same time. So basically we were fortunate enough to be able to raise the funds for the facility you're in now.

This building we moved into in December of '82. Tore down the old building, put in the parking lot, and actually only lost two days of operation. And as you know, like many health centers, we offer a full range of services, adult medicine, pediatrics, dental care, social work, mental health, a large pre-natal service, which is a professional service of Durham Community Health Department, located here ever since the center opened. And we also have transportation. And we have many, many specialty clinics and some special clinics like our diabetes program. We also have a homeless shelter program, mental health care for the homeless, and a school-based program at Hillside High School, and an early intervention program which was initially started by the health department in February of '91.

And we worked with them then and then were able to get Ryan White III funds available to us, to the health center, and we now have a program that's operating every day. And as you know, Durham has a high number of both HIV-infected individuals but also of AIDS cases, so it's very important that we recognize that need.

AK: Can I pause here for a sec? First, you're telling me the history of the health center, which is completely useful and very good for the interview. Could you tell me what year did you come on board and what was your professional role?

ES: All right. I came on board September 1, 1971, and I came on as the executive director.

AK: When the health center was created.

ES: No. Actually the grant was awarded in mid-June of 1970, and staff had been hired. I was actually the last person hired, and then we became operational mid-September of '71. At that time, when I came, I was executive director, but I was also the only pediatrician. So as we grew, fortunately very, very soon, Dr. Samuel Katz, who was the head of pediatrics at Duke, came over and said, "Anything I can do to help you? Would you like to have a resident in January?" And I said, "That would be great." [Laughs.] So that was our first affiliation with Duke in the sense of residents. We now have them not only in pediatrics but medicine, so that it's an elective in community psychiatry in the P.A. program.

So we have nursing school students from all the nursing schools around. But the very first one was really very critical at the time with the offer of some pediatric assistance.

AK: OK, great. Just to get your impressions of the community from your perspective of someone who had been at Duke and who had been away and who had come back and now was based much more in the Durham community rather than just with Duke.

ES: That's exactly right. Yes, I was on the other side of town. That's exactly right. And although you now had legislation which said that people could go anywhere, as far as health care was concerned, which was a concern of both the professional and lay community who started Lincoln Community Health Center, and very much Dr. Charles Watts, who actually was the very first Board-certified African-American surgeon to come and practice in Durham in 1950. Basically, you still saw the needs of large groups of individuals who didn't have access to health care as they should have access to health care. And I think that's the reason that health centers were started, was that no one regardless of any barrier--and the barrier shouldn't be race, it shouldn't be ethnicity, it shouldn't be money.

AK: And it was all of those things.

ES: All of those, in many, many ways. In terms of the basic health needs, which provided not just emergency care but ongoing care. You don't cure anything, or you don't treat adequately anything just on an emergency basis. You maintain life, but you don't really necessarily treat.

AK: And so when the health center was created, then you came on board, you worked and have worked with the community board.

ES: That's right.

AK: Now how does that process work?

ES: Initially, of course, you didn't have any patients, so your representatives for the consumers were many of the organizations that were consumer-directed organizations and as you got more and more consumers, they became the majority. And the agencies you work with are people you work with, Social Services, Health Department, Duke, North Carolina Central University, Council of Senior Citizens, groups that they're not remote. These are actually institutions that work with you in more ways, in helping to provide care, and in a policy issue way.

AK: Now in my mind I would think, being in a historically African-American series of neighborhoods, that you would have both white and African-American constituents that would use the health center. How was that in the beginning?

ES: I think it was always and continues to be predominantly African-American, with a small percentage of whites and now a small but growing percentage of Hispanic patients. And the bond for most was low income. We always hope that as people get insurance they'll stay with us, but that puts you in the mode if your services are competitive with other services both in patient satisfaction, quality of care, and in easy access.

AK: So now maybe we can move more towards current times, and if you feel like there's anything as the health center developed--?

ES: I think the most significant thing has been the change. In other words, each year, again, because we are federally funded, we're fortunate in getting some support through the hospital corporation. And we're very lucky that way in getting some on-site services and also getting the discount services, which enables us to do a lot more with our federal grant in direct patient care than what had been possible. But the nation is still not

facing up to the needs of the growing uninsured working force. Also Medicaid eligibility varies from state to state, as you may know.

And like so many states, you begin to see industry divided between technology and service, and of course there are low-income jobs in service, regardless of whether it's food service, health service, any other kind of service. So even though your unemployment rate is low, that does not tell you the problems that exist.

AK: You're nudging at current issues, current problems.

ES: Well, current issues that really affect everyone, and basically, as I said, we seem to keep ignoring the fact that there's rising uninsured in the country. And the changing fields of employment have really not negated the fact that we're going to still have jobs that pay if not minimum wage, not much more than minimum wage. So you also have the fact that many industries now are hiring on a part-time basis, depending on the seasonal or other needs of the industry.

AK: And as the time has gone by, you see the impact of those truths on--.

ES: On Durham. You see it in people coming--.

AK: On Durham and on the health center.

ES: Right. And as a federally-qualified health center, we use federal quality guidelines, so when an individual comes in, they know up front, based on income, what they're going to be paying. And if they're at or below a hundred percent of poverty, it's a nominal fee, and if between poverty and two hundred percent of poverty, it's a discount, depending on the numbers in the family.

AK: So a sliding scale.

ES: Oh, yes, it's a sliding scale. I think one of the advantages that we have provided for patients in addition is transportation. The bus transportation means you still have to walk some blocks, and if you're elderly and you have a chronic disease, you're not going to walk those blocks.

AK: Now did the health center start with transportation services and have it the whole time?

ES: No.

AK: Which is unusual, I think, even for health centers.

ES: Well, we do a lot, and basically we transport you based on medical and/or financial needs. And therefore we have a high chronic-disease population in terms of our older population and we're able to accommodate the pre-natal moms too who need transportation. I think the changing scene has been the fact that we noticed some years ago--.

AK: Around when?

ES: Around '92, that we were seeing an increasing number of Hispanic population. And if you use the calendar year, we went from two-plus percent to four-plus percent, to seven-plus percent, to nine-plus percent. And in 1998, thirteen point six of our individual users were Hispanic.

AK: So from '92 to '98, you went from basically two to thirteen to fourteen percent. You jumped ten to eleven percent at least.

ES: Now one of the things that concerned health centers very much is that the immigration laws, as you know, make it very difficult for people to know what services they are entitled to, what ones they can get on an emergency basis, what ones they never

can get, what ones they jeopardize in terms of their legal status. Health centers have always said in objectives that basically we should not have to ask, as we differentiate ourselves from those places that had to. And at long last, just several months ago, we officially do not have to ask you whether you're legal or not. Very frankly, I don't think either education or health should be made to police it. We should be delighted that people want to be educated and that people want to be healthy, because this actually adds to our economy.

AK: So when was the health center officially able to say--?

ES: That was in the latter part of '98. But we never had to ask. But the negotiations to make it official were going on, and those were finalized so that we were never put in the position of having to ask like some of the agencies that are required to. We never were, but the question was, whether we going to remain that, or were we going to be pushed into that classification where you had to. And so, we don't. As I said, my personal view is health and education should not be the barriers.

I laugh to myself, because we would not be a nation if we did not have immigrants. And many of us would not be here if it weren't for our parents, grandparents, or great-grandparents, who migrated to this country for one reason or another. So as I said, once you're here, want you healthy, want you educated, because as in many of the previous groups to come in, many of the people coming in are taking jobs that have not been filled before. Others are coming in and bringing resources. I think that we've been enriched by the community. I laughingly say we have a culture now which adds to our dimension of music and art and also culinary! [Laughter.] So let's not, I mean seriously--.

AK: Limit our resources.

ES: Yeah. Let's look at the enrichment that comes to your community too when another culture comes in and brings its heritage as well as themselves to your community. But as I said, I think, on the other hand, we really have to be able to say, "Do we have the access for people to get the services they need?" And we're so monolingual in this country, because you can go three thousand miles and speak only English, unlike in Europe where many people--and they don't have to be college graduates--speak several languages. Our immediate response is, "Why aren't you speaking English?" not realizing maybe this is an opportunity for us to begin to educate in another language. I laughingly say we could have a generation that's bilingual if our kids could learn Spanish in grade school and on through high school. They could have friends that they could talk with and use it. That would be good for whatever kind of business, trade, or profession you go into.

AK: I want to jump back just a little bit. You were talking about how with immigration laws the way they had been, and in some ways continue to be, that it's difficult for the Latin American population, in this area or in many areas in the US, to get the right information about where they can get services, what kind of services they can get.

ES: For instance, as you heard, now we have CHIP, which is the Child Health Insurance Plan, which is really very good, meaning families between a hundred and two hundred percent of poverty now can qualify for an insurance plan which is not Medicaid but is being handled by the state employee insurance, which is actually handled through Blue Cross/Blue Shield. And basically it's a very good plan because it has added the

enhancement things that Medicaid has, like hearing, vision, and dental. And if you were born in this country, you are eligible, but you have to help the family understand that they are not jeopardizing their status. In other words, the family may not, or some of the other kids may not be, but if you fill out the form, no one is going to come after you in terms of your status.

AK: Now this is what I would ask is, did you or did the health center staff, have experiences--? If you can offer any anecdotes or stories or types of experiences from '92 on.

ES: Only in that we recognized that we needed to be sensitive to the newer population coming in. I remember when a Hispanic woman came down because, she complained, she felt that she was being discriminated--. What I realized was that sometimes when you don't speak the language, you sort of hold back, and it looks like you're being negative. It's your own inability to communicate that's reflected. And so met with staff and explained to them that body language means a whole lot and that we really to try and get some interpretive services for them. But in the meantime, your body language tells.

Well, staff really took that to heart, and we've since hired some translators and tried to get some bilingual staff. But as I said, for the moment at least, people felt that they wanted to help. It might take a little time till we got someone to translate, etc., etc. At the same time, shortly after that incident, I was walking in the lobby and there was this man. He had a little African-American youngster on one side and a little Hispanic youngster on the other. And the kids were looking at a book and pointing like to a horse. And one youngster would say it in English and the other youngster would say it in

Spanish. And I said, "If we leave it to the kids, we can get the world's problems settled." But it's that kind of exchange of communication that we should be promoting, whereby we learn as well as they learn.

AK: At what point did the health center begin to have interpretation or Spanish services?

ES: We've had a translator for several years now, then we added a second translator. Now we have someone who's bilingual at the information desk. We have some bilingual people in finance. We have bilingual people scattered in some of the other services, so that again there was recognition that this was the new population coming in that needed to have services.

And again it isn't just us. They need to be able to go to any of the agencies and be able to feel that they're comfortable. And the agencies feel comfortable, because if they don't speak the language, there's interpretation service available to them, because sometimes I do feel sorry for staff too. They're not necessarily bilingual and suddenly they're being besieged with questions they can't answer and there's no support for them to get the help. So it's a two-fer, on both sides. As a public agency, people are entitled to services. Now you're going to have to be able to offer those services in more than one language.

Here we only have one language. I know of one of the New England centers, they are infiltrated with many, many people from the Asian countries, and one of the centers has umpteen number of dialects that they have to be able to deal with. So we're only really having one major. We have others. We do have some coming in from other parts of the world, but basically only one really major. Because people are moving into all

parts of our country, and as you have noticed, I mentioned to you before, the paper said a few months ago Durham County is the twenty-fifth fastest growing county for Hispanic population for the years 1990 to 1996. And you are beginning to see many of the states--I call them the inner states rather than the border states or the coastal states--that are seeing populations moving around, because people are going where they think there are job opportunities, whether it's construction--.

And although North Carolina has always been a large migrant state, as you know, that's where I think we mentally still only had people in the migrant--moving, right? Now suddenly you are seeing them settling into your urban areas or your surrounding areas to your urban areas. And bringing not just medical problems to you, but bringing the problems we all have, whether it's spousal abuse, child abuse, drug use, all of the problems no group is exempt from, economically, racially.

AK: So they need the same services.

ES: They need the same services as everyone.

AK: Now I'll ask you another question that's very related, because what we've talked about so far, most of it has been oriented towards a difference in language.

ES: Customs.

AK: Yeah, it is culture, what experiences that the health center has had with that.

ES: That's something we're still learning. Once you can begin to use the language, I think you realize that there's more that you need to know about people and their customs and their health habits. So many of the other countries have been much more into herbal medicine. I'm not saying this in Hispanic. I'm just saying in general. But of course now we're all getting into it. [Laughter.] It's not so different any more.

I think the first block--people always are concerned--is if I can communicate, then I can find out a little more. And I can find out what I don't know. You can have people in community health, don't get me wrong--.

AK: So you feel like now the center is entering the stage where they're beginning to explore that.

ES: Right.

AK: I was just curious, because when I was working at a health center, most of it vaccinations, in Arizona, that was a big concern for many women that were coming across the line from Mexico. Even if they had an address they could use in the US, they were basically coming in from Sonora. And had very different ideas about if you could introduce fluids into the body, and whether that was good or bad.

ES: I'm only saying a little bit because I'm not up on the floor as much as I used to be, but people seem to recognize the need to get their immunizations, when you explain it to them and everything. Some have had it, of course, if they're coming from Mexico. They're coming from a country with immunizations, so it's a matter of do they have their record or do we have to start all over again? That is the other thing. Then you've got to be sure that it's the immunization. In some places, they were only giving measles rather than the three, the MMR. Then you has to be sure of what measles they were getting.

Again, that's being able to communicate, to get a little bit of sense of where they came from, what was it like, small town, where you got your health--. These kinds of things. A little bit of the geographics of where and what was available to them in terms of health. And many of them coming now do have a card.

AK: Just generally speaking--not being on the floor so much, it might be more difficult--but if there are trends in terms of services or services that people have either had a problem with receiving or hadn't received as much or have received here--.

ES: OK, now. One of the greatest unmet needs for low-income people, uninsured, is dental care. If you come in any morning, if you get here before nine or nine-thirty and sign in, you will get seen. You may have a wait, but you will get seen. And this is a real need, because if we don't see you, practically the only other place is the University of North Carolina school of dentistry.

AK: So that's been a really highly-used program.

ES: Then a lot of our pre-natal. I think I heard their supervisor say that better than forty percent of their moms are Hispanic now. And they had maternity care coordinators, and they were prepared, I think, earlier than even we were, because of the influx of women needing services. So I give them a lot of credit, that they had maternity care coordinators, several who were Hispanic. They started a small group here with our employees and some other organizations called the Abriendo Priortas, which means once a month, to look at some of the needs of the Hispanic population more broadly. And basically, if you are interested, their next meeting is the 17th of this month at noontime. You'd be welcome to come.

AK: Do you know the names?

ES: Yes. Again, there's been some initiative on the part of staff, which I've admired. One of our interpreters came and said that there were a group of Hispanic women who wanted to have English classes here. I said, "If you can find a teacher and just check the conference room." So over the past year, they've been giving classes in

English. And periodically we have a class in Spanish for staff who are interested. But that was very interesting, because the women were comfortable in coming here.

This past year, we were the only site in Durham for the National Depression Screening Day that they had, and we were able to offer the service in both Spanish and English. And I think what we're not being able to serve as well are the social, mental-health needs of our Hispanic patients, because they're no different than anybody else.

AK: And so far that's been a difficult area to--?

ES: And I think we need to recognize that. I went to a forum once in which students were giving their findings. They'd studied the Hispanic community, and then they had some people from the community get up. And one of the women got up and talked about the abuse that she had sustained, and I think we need to realize that regardless of whatever background you are, we do have spousal abuse. And as a matter of fact, one story: a couple years ago now, a women came in with a little boy. Her husband brought her in, and it was interesting. It was late in the day, and usually what we do is triage, because you can't see everybody who walks in. And then if it's urgent, yes, we'll see them, and if not we'll say, can you come back tomorrow morning and we'll see you, etc., etc.

Well the translator who was at the desk came over to the head nurse in medicine and said, "Can't you see this lady? She had a cold and she's coughing." And so the nurse just said, "Oh, Peggy, for you we'll do it this late." Fortunately, the resident spoke Spanish, a Central American gal, and I guess that when she pulled the patient into her room, she must have greeted her in Spanish, because as soon as the door closed, the real problem was she was being beaten and abused by her husband.

So we immediately called Battered--. The husband wanted to come in the room. We wouldn't let him in, and they took her to a shelter. The last I heard was they were able to have her and her little boy returned back to her parents' home.

AK: So she had gotten in a bad situation and she felt that this was a safe place to come.

ES: This was the only place she could come. The only excuse she could have was illness.

AK: To get out of the house.

ES: And that's not too different than many American women. So what I'm saying is, we've got to recognize regardless of where you come from, you're dealing with the same problems. We're dealing today trying to get young people to understand the need of prevention not only of HIV but the STDs. And it's interesting that the Hispanic community group has a new project to be able to talk with the Spanish populations about STDs and so forth. And that young lady is coming over here Fridays to work at our place.

So it's just working together. As you know, HIV is now a problem of the young, because for whatever reason no one is hearing we don't have a cure. It's still prevention. You're in charge, all right? [Laughs.] And I ( ), but it truly is very sad, and of course the latency period can be very long.

AK: Let me ask you another question, which is just related to the different things you've been telling me. Well, I'll ask you one to begin with, which is, as you started offering more services, you had some staff that were bilingual or spoke some Spanish and you added interpreters. How did you feel that the health center was sitting in terms of the

entire Durham services community? Did you feel that there were not many services offered in Spanish or that were attuned to a Latin American clientele?

ES: Yeah, I think early on not. I think you're beginning to see more awareness now that some of the other public agency types are having interpreter services available. As I said, the health department and prenatal service did very early. They were the first ones in terms of maternity care coordinators etc. But I think you're seeing that some of the other services realize that they need to have that capability. And I think also, you need to make it not just available, but you have to make people feel comfortable giving it.

One of this things in this country--and I'm not talking about Hispanic populations--is many of the populations who've had to use public services have been turned off and feel that they're not treated with the respect and courtesy. Because these are services that everyone is entitled to. Most people have contributed to them at some time in their lifetime, and you always hope you're contributing and you don't need 'em, but if you need 'em you shouldn't feel that you're asking for anything you're not entitled to. And I think it needs to be given with the same kind of respect.

AK: It seems like that's a philosophy that has sort of ( ) through the health center.

ES: Yes. Sometimes you do have to reach out and make sure you're getting to what I call the disenchanted population that just feels it can't walk in any longer to whatever the public service happens to be because of previous experience. And you see that sometimes in your homeless populations, where really they need it but they've been so turned off. And you've got to get out and reach them and let them know that these are

available, that you do care. So sometimes you need to bring some services to where the population is, all right?

AK: Let me flip real quick.

END OF TAPE 1, SIDE A

START OF TAPE 1, SIDE B

ES: Sometimes you need to bring things to where the people are. And then if they need greater or more intense kinds of care, whether it's medical care or social service care, they will feel comfortable in going, because you've formed a bridge that says, "I'm comfortable. I trust you."

AK: And so far, the main way to form that bridge has been language services and a simple way of demeanor?

ES: That's exactly right. And where you can, if you can get out and bring some services to people at sites where they happen to be, whether it be at homeless shelters or other types of group homes. And you need to be sure, like I said, that there's decent living conditions, and I'm talking about housing. The people with the least always are faced with terrible, terrible housing.

AK: Do you all find yourself in some ways connecting with the community, to help in that way, to partner--?

ES: There's no way that we can do all of it. I'm just saying that--.

AK: You're seeing the whole picture.

ES: The whole picture, right. And you hear stories and you're not surprised because of the number of slum housing that's still allowed to exist. And new groups then usually are taken advantage of, moving into it.

[Phone rings. Recorder turned off and on again.]

ES: So basically, as I said, there are just a number of issues. But again, a healthy environment means a decent place to live. From a medical point of view, you're not going to cure certain diseases if the living conditions are either inadequate plumbing,

roaches, falling plaster, many of those kinds of things. So again, this is not new, but it's sometimes the newest groups coming in that are going to be ending up--.

Did I mention to you that Massachusetts recently did a study in 1998 on hunger? And of course there's hunger in the ghetto. Massachusetts has an unemployment rate of four percent, but they were seeing, like many of the states, where you're converting into either technology or service, you have a lot of low-income jobs. And what they were finding out of course is no one ever builds low-income housing. So people were spending sixty percent of their income for rent, and the only thing they could compromise on was food. And I'm sure that that study could be repeated in many other states, not only in Massachusetts.

And of course their big thing is to be sure there's adequate school nutrition programs, breakfast, lunch, after-school snack programs, and that during vacations there's adequate feeding. So they're very much using it to increase what they can do in the public sector.

AK: So in terms of the whole picture and helping with the whole picture, what I heard you saying before was some women asked, in the communal program, "Well, we want to have an English class. Can we have an English class?"

ES: No, not the communal program. This is just women who were coming in and speaking Spanish.

AK: OK. And the health center was in terms of the Durham scene especially, one of the earliest public service programs to be established in Spanish.

ES: I think so. And the patients appreciate it. Don't get me wrong. Not that they couldn't see there couldn't be more services. Don't get me wrong, but at least they were appreciative of the fact that people were trying.

AK: And so what I wonder--hearing about that and hearing about the woman coming in and saying, "This is the only place I could think to come where I could get away from my husband to be sent wherever I can be sent"--is if you all as service providers for health and being one of the first service providers in Spanish, if you had the Latino community coming and saying, "Can you refer us? Where can we go for this?"

ES: We'll send people. You use the other resources in the community.

AK: But did you all find yourself referring?

ES: Well, we always referred a few of our patients. We'd refer them to Social Services for appropriate assistance where they can. So we've always done that for any group. The question comes in to be sure that the other groups you're referring to are able then to meet the needs, because again, unless you can communicate, you're not going to find out what the problems are. And I think there's an awareness in the community now in general that this is a permanent group coming into our community, settling in, and that we need to look at how we're able to offer the appropriate services that the Durham community has.

I think the awareness before was that this was a migrant community. You had the apple pickers in the western part of the state, and then you had tobacco and others in the eastern part of the state. You were always dealing with the conditions of the migrant workers, which weren't always very good. This is a moving population that you had to seasonally be able to provide certain services for. And now we're seeing that this is an

integral part of your community. And you begin to see more churches offering services in Spanish now. If you notice on Sundays, as you pass, you see the little calendar on the outside and you see that they are offering bilingual as a part of, or in the evening, but nevertheless recognizing that there must be some services in Spanish.

So you're beginning to see a slow transition, a change in recognition, and as I said, of course, then it's helping the newer people coming in, recognizing where they can get services. And they have a couple of very active groups here in Durham in terms of the Spanish community, because they're very ( ) and they will help you too. So they're there trying to help the Hispanic population, whether it's English classes or other kinds of education or training classes, also trying to help those of us that are trying to help be of better assistance to the population. So, as I said, I think you'll begin to see them much more. Right now, they're getting established but much more of an active, vocal part of the Durham community.

AK: And you're actually leading to a question I was thinking of asking next, which is, have you found that now there's interest from the Latin American community on an individual level or on that larger organizational level, interest in planning with the health center, in working with your community board?

ES: Oh yes, we're old friends. As I said, ( ). I think one of the people you should be interviewing is the two leading groups.

AK: Well, a couple of organizers are actually involved in planning this oral history project, and will be co-writing grants for future projects based on this.

ES: Yes, and I hope you can work even closer with some of the groups in terms of looking at services which are still lacking. But as I said, it's a change which you want

for the whole community. And I think that says it. It has to be a whole community. No one organization is going to do it alone. I'm sorry. It is a total community, and recognition that the newer group is important to the community. It's important for the economics of the community. These are working people that are contributing to the community, and therefore we have an obligation to be sure that services are available. It's a two-way street.

AK: A slightly more personal, individual question, which is something that I sort of realized was how I got interested in doing this kind of project, which is the history of my own family, that one side of my family immigrated, my grandparents, and hearing those stories and being interested in how that related to what it's like to immigrate to the US now. And what were the challenges at the point my grandparents--and what are the challenges now? Because I hear you being very passionate about the policy--.

ES: Well, it's like anything else. I think in the past, if you read about any group coming over, you had groups that tended to stay within themselves, so you always had them retaining a whole lot of their own culture. Sometimes their own language was very little, but they were able to negotiate. With other pioneers who went out in the broad community and became a part of it, so you have the same thing I think happens with any immigrant group, all right? I think when they tend to come in in a larger group where they can get some feelings of support among themselves, that is a positive and a negative from the point of view of the rest of the community.

Because then they say, "Look, they don't want us. They don't take as much interest because they've got their own group." Rather than looking at it a little bit differently and saying, "What are the services that we can offer, regardless of whether

they're able to communicate with their own group or have their own store?" They're very much like the earlier communities. If you have your own stores, you could communicate, etc., etc., but it didn't mean that the broader community did not need to make the services available.

So I think we see the same thing happening in any group. Sometimes if you have people come over in a small number, you can have people become their sort of benefactors and take them under cover. But when people come over in larger numbers, you don't have that outside benefactor as much, all right? So the strength is the fact that you've got the group. On the other hand, you still have to be able to learn and need to be able to access the services of the broader community. So I think in some ways, if you know anything about immigration and what happened with people who came over in the past to this country, you see some of the same things. The independent pioneer who went wherever it was, maintained his own culture, but picked up the other because that was the way life was and you existed. And then you had others who were able to get into a more comfortable environment where they could feel more comfortable.

So you still see that same kind of situation coming in. And you tend not to have as much concern, I think, as there should be on the part of the broader community when they see the cohort of groups that are able to function among themselves. And I think that's what has to be different today, because we are a different society today. And so you can look at the present and say it doesn't mean you have to lose your own culture, etc., but you're going to be able to be stronger, and we're going to be able to have a stronger community, if you're able to utilize the services and understand and feel comfortable.

AK: It's always really interesting to hear different perspectives of different people who are working in different professions and backgrounds, because you just see the relationship between their political ideas and--.

ES: And you also see people who have brought a lot to this community, in terms of being entrepreneurs, whether it's in the cultural area or culinary area or other commercial areas. And then in turn have become employers. It's just something, I think, different for such a long time, when you did not have migrations extending into the South or into the cities more. Whereas in the Northeast, you always tended to have groups. As I've said, in part of the Northeast, there's been a real Asian migration as well as the usual coming from South America.

AK: Well, I guess let me just ask you if you had anything you wanted to add or if you feel like you've said your piece.

ES: No, if I've covered what you wanted.

END OF INTERVIEW