Dan Murphy 1971–1977

In December of 1977 I finished six years of work at the Rodrigo Terronez clinic in Delano, California. This is my version of the story of this clinic.

I am from the small town of Alton, Iowa. I went to school at the University of Iowa, graduated from the University of Iowa Medical School in 1970, and went to New York City for my internship. While in New York City, I became quite active in the anti–Vietnam War movement. I was eventually drafted, but refused induction and was convicted of a felony but received a suspended sentence. It was then that my political opinions began to develop and I became quite strongly anti-establishment. My wife, Janet, and I were looking around for alternative jobs. She was a Spanish teacher, and I had just finished a rotating internship.

At that time the United Farm Workers were beginning to form a clinic in Delano, California, and were looking for doctors. Migrant farmworkers in California had been involved in a long struggle and had just begun to accomplish some of their goals. One of the things they had always wanted was to have their own clinic.

When we arrived in July of 1971, a permanent Delano clinic was just beginning to be built. It was built from two old chicken coops. There were four doctors who arrived at the same time and we were put to work constructing the rest of the clinic and developing a plan for operating the clinic. Along with farmworkers and other volunteers we worked much of the day pounding nails, painting, and putting the clinic together. Much of the night was spent in trying to figure out a plan for the actual functioning of the clinic.

We also had long, numerous meetings with the union leadership and the board of directors, discussing every possible detail of how the clinic would run, what would be the best for the farmworkers, and what kind of services could be offered. Cesar's original idea was to use doctors as barefoot medics. They would go with their little black bag out to the fields or wherever they were needed at that time and try to do what they could. We doctors were against this idea and wanted to have a modern clinic where patients came in to us and we could actually do something to help take care of them. Many times our meetings would start at 8 a.m. and continue past midnight, almost without interruption.

Cesar wanted to know every detail of every plan. Sometimes we would have to meet secretly because at that time there were numerous threats on Cesar's life. We would have to drive to Visalia, go to a phone booth, call a special number, and then get directions on where to go next. Then we would meet in a private home somewhere with all the shades down and try to figure out how we could get the clinic going.

Originally there were four doctors: Dr. Peter Cummings, Dr. Caleb Foote, Dr. Peter Rudd, and me. Dr. Foote had done a surgical internship and the other two had done medical internships. All were planning to go on for further training eventually and were pretty high

powered academically. I had done a rotating internship and had no long-range plans. I took a practical approach to most things.

We had to plan everything from the organization of the charts, to choosing all the equipment, including what kind of book would we use for scheduling appointments, how many needles we would need, what kind of a defibrillator, etc. We went through our medical books and pharmacology books trying to plan what kind of a formulary we needed.

We had to plan a medical library. We had to get in touch with specialists and develop referral systems and figure out how we could fit into the established medical system. We had to decide what kind of services we could offer and what the hours would be. We had to decide what we would do for emergencies. All these things had to be determined. Fresh out of medical school, we had no idea how to go about any of this.

Everybody contributed what they could. Peter Rudd was a real organizing type and believed in getting things down to the last detail. In the long run, a lot of this careful planning came in handy, and actually, without it, I doubt if the clinic could have functioned in its later years. We all had to learn Spanish, and we all had to learn a lot of medicine as we went along.

Finally on October 21, 1971, the clinic opened. We had a big opening ceremony with thousands of people present. There was also a small group of people that picketed against the clinic on the outskirts of the property. This was to be expected. Everything that happened was political. There were always two sides to every issue.

Our clinic was primarily an organizing tool. We hoped that by delivering top-quality health care to as many people as possible we would convince people to back the union by showing them that there were benefits to having a union.

On our first day of operation I think we saw about 40 patients. People would walk in and the receptionist would check and make sure that they came at the proper time. We worked on an appointment system, but also accepted walk-ins. The people with appointments were always seen first unless they came more than 15 minutes late or if there happened to be an emergency. The receptionist would write down all the data and then the patient would go to the record room and get their chart pulled. Then they would wait to be called by the health aide. They would be brought back into the exam areas and weighed; their temperature would be taken; and their blood pressure would be checked. Then they would be put into the examining room. The doctor would come and see the patient. The patient would then go to lab or x-ray, as needed, and then would go to the pharmacy and get his medications. Then he would go to the payment office and the receptionist to get a future appointment, if needed. That was it.

The clinic itself, when it was all finished, was quite modern. We had a large waiting room and seven examining rooms. We had a fully equipped emergency room. We had a small room with several beds in it where we could keep people for short periods of time. There was also an x-ray room with a small x-ray machine where we could take chest x-rays, x-rays of bones, and IVPs and UGIs. We didn't have fluoroscopy. We also had an automatic film developer. This was all donated by the International Garment Workers Union. We had a little room with a big film view box, which came from the TB Hospital in Keene, California. We had a pharmacy, a record room, and administrative offices with a small conference room at the far end of the clinic. We also had a large doctor's office where each doctor had a small desk. Our medical library was along one wall in the office.

We always kept the most modern textbooks and tried to have one textbook in each field. We also had a couple of file cabinets where we kept "article files." These references were very important in the functioning of the clinic. Having things conveniently located right in the doctors' office made it easy to refer to textbooks, which we did liberally. We always figured that if we could save one referral to a specialist by using a textbook, this would save the price of that textbook.

We had designed the entire health care insurance system, and we were very conscious of how much money there was and how much could be spent. One consequence of this was that little by little we began doing more and more things ourselves. Luckily, there were four of us, and we could get together and consult on cases and come up with an acceptable answer most of the time.

Our charts were set up according to the problem-oriented method. Each individual member of a family had his or her own chart. All these charts were, in turn, kept in a big folder for the entire family. The charts were filed according to the head of the family's Social Security number. Inside the chart on the inside cover was a data sheet with patient and family data such as birth date, address, telephone number, etc. Then clipped together and separate inside the chart were the progress notes. On the back cover inside the chart was the problem list. Underneath the problem list sheet we kept all the other medical information, which included things like records of vaccinations, laboratory and x-ray results, letters from referring physicians or specialists, and any other pertinent medical data. Underneath the front cover sheet we kept all the insurance papers and disability claims and this sort of paperwork.

I firmly believe that by having an organized chart we were able to deliver much better medical care and run the clinic much more efficiently. It was very easy to pick up a chart and see which problems the patient had and get a firm grasp of the whole medical picture. This enabled a doctor to put things into perspective and come up with the proper answer much more readily than if you had to deal with a disorganized mess of papers and try to put it all together every time you saw a patient. Even though paperwork is not the most fun thing in the world, I think having the chart organized in this manner paid off.

One of the most important aspects of the clinic functioning was what we called the "work order sheet." This was a small piece of paper that we designed and which was used for every patient. This piece of paper sort of led the patient through the clinic and kept him going until he got to the other end and went out the other door. Every time we would see a patient in the examining room, we would check off what things were needed on this piece of paper. The paper was NCR and you could use multiple copies and the writing copied through on all the pages. If a patient had to go to the laboratory, the needed tests would be checked off. Actually, for the tests that were done in our own laboratory, the results could also be written on the lab copy. Then the patient would continue with the other copies. If he had to go to the x-ray room, another copy would be dropped off there, then he would go to pharmacy, etc. When he ran out of copies, he would know that he was through. The last person who saw this patient could see if everything had been checked off and done. It was a very efficient way of having the patient go everywhere he had to go and minimized the amount of mistakes. No one had to follow the patient around and make sure that people kept moving because the patient would always know where to go next and what to do next. This was so efficient that on the occasion when we would run out of these papers, the clinic dropped down to about 50 percent efficiency. It was very surprising to me to see how this kind of well-designed bureaucracy, if you want to call it that, could really accomplish a lot. Because it worked so well, even to make a minor change on this paper became almost impossible because the functioning of the clinic depended so much on going right down the line with this little piece of paper. With this kind of set-up we were able to see large numbers of patients and do our job very efficiently with a minimum of personnel.

When we compared our clinic to government clinics, our budget and personnel were usually around 10 percent of a comparable government clinic, and usually we would see double or triple the number of patients that they did. Our clinic had no government finances. We received our funds from the union. The system was that for every hour worked in the fields, the employer had to put a small amount of money (it started at 10 cents per hour) into a health fund. From this fund we developed our health care system and insurance policy. This money was used on a prepaid basis to help finance the clinic operation. There was also a small fee, which began at $2 for a patient visit to the clinic and $2 for any amount of laboratory work, $2 for x-ray, and $2 for any amount of drugs. Through this prepaid concept, we were able to take care of the sickest patients without adding the burden of higher costs if they used much more of our services and needed more laboratory tests and more medication.

Our clinic was open 24 hours a day, seven days a week. One of our proudest claims is that from October 21, 1971, until December of 1977, we were open every minute for full services. We took appointments only from 11 a.m. until 7 p.m., five days a week. The rest of the time there was always either a nurse or an aide or a doctor on the clinic premises. Full services could be given if needed. Much of the time we were open on Saturdays and Sundays and took Tuesdays and Wednesdays off for appointments. This was so that people wouldn't have to miss work to come in and see us.

When we started we had four doctors, but after two years, three of the doctors went on to further training. Another doctor, Dr. Gary Okamoto, came and stayed for one year. After that, a doctor by the name of Mark Sapir came and worked for close to a year off and on, and then for approximately three years there was just me. All of this time, we had a steady stream of medical students, nursing students, volunteers, nurse practitioners, physician assistants, and community aides working at the clinic. Little by little, paramedical people took over more and more of the functioning of the clinic and accepted more and more responsibility. Actually, this is the only way we could function, but it worked out very well. The patients accepted this system very readily. Our advantage was that we were a union clinic, and for a farmworker, this was the best possible choice. A government clinic was seen as a handout, and private clinics were seen as a rip-off. When you are sick, you automatically want to go to a place where you believe people are genuinely concerned about your health problems.

I think our medicine worked much better because we were a union clinic. The political factor added to our motivation and also boosted patient morale. We did have a lot of union propaganda scattered around the clinic, and signs and banners were up all the time, as well as informative leaflets. But our main concern was health care. Although we did keep up on what was going on within the union, we did not aggressively proselytize. However, many patients would automatically start discussions about the union. We were also very visible in the farm community and spent a lot of time going to union meetings, going out into the fields, discussing worker health problems, work-related problems, and also new programs we were trying to initiate.

We spent many hours on picket lines. Several of our doctors were arrested on occasion and were in jail during the big strikes. We were constantly called to various jails in that area to visit injured farmworkers. Doctors from our clinic were present when Nagi Daifullah died in the hospital following surgery for a skull fracture at the hands of a current county policeman and also at the death of Juan De la Cruz, who was shot by a scab while on the picket line. One of the most dramatic things I have ever seen was the procession we had for the funeral of Nagi Daifullah, when 10,000 people marched carrying his casket for the three miles from Delano to our clinic at the Forty Acres.

The people who worked at the clinic were constantly involved in all sorts of political activities. We had a very active outreach program with staff who spent most of the day either out in the fields or visiting people in their homes in labor camps. We hospitalized patients only when necessary, which amounted to approximately 5 percent of the national average, as much of the care was done in the clinic or in the homes. This outreach program was one of the most popular parts of the clinic and helped politically very much because people had never seen anything like this. To have a clinic of their own was almost an impossible dream, but to have someone who would come to their home to find out how they were doing was absolutely unheard of. I think this program helped the union politically immensely.

In the clinic we averaged approximately 100 patient visits a day. The most common things we saw were viral illnesses, upper respiratory infections and gastroenteritis, high blood pressure, prenatal and postpartum visits, tuberculosis, well-baby checks, and vaccinations. We also saw what we classified as psychosomatic illnesses. We had a lot of low back problems and arthritis. There was a fair amount of trauma. We saw drug problems, heroin overdoses, and all the common diseases that are seen in any general practice. We also saw many rare diseases that are not seen in the average practice.

About 70 percent of our patients were Mexican-American or Mexican. Many were fresh from Mexico. A large number were illegal aliens. About 15 to 20 percent of our patients were Filipino immigrants. Two thousand patients were Arabs from Yemen. There were also small numbers of Japanese, Chinese, black, white, Indian, and almost every other group of patients that you can imagine. We pretty much had people from every part of the world and, therefore, ran into diseases that are seen in almost any part of the world.

Living in the San Joaquin Valley, we became experts at valley fever, coccidiomycosis, and almost constantly had these patients in the back of our clinic getting amphoteracin B. We were also experts on tuberculosis and saw every form of that disease from minimal tuberculosis to TB meningitis. INH for tuberculosis was the number-one drug used in our clinic. Fifty percent of the Arabs had a disease called schistosomiasis. In the first several years of the clinic, we did a lot of study on this disease. With the help of Dr. Warren from Case Western Reserve in Cleveland, we developed a diagnostic and treatment plan for schistosomiasis. Through a special FDA permit we were the only place in the United States giving a certain drug, niridazole—the outpatient treatment for schistosomiasis. Once we had this program developed, an Arab patient could come in with schistosomiasis and be treated as efficiently as someone with a cold. Our laboratory was expert at diagnosing this, and we became quite proficient at treating this illness.

Because of our patient population, we did see rare diseases including leprosy, trachoma, malaria, and almost all the parasitic diseases. Because of our high volume of cases, it seems that we ran into almost every disease imaginable. We saw all the collagen vascular diseases, every type of cancer, and many rare kinds of diseases that were brought to us because people did not have access to medical care where they came from and we were very accessible. They also had faith in what we did and, therefore, were willing to bring us cases that they had been kept at home for years for or that they were afraid to bring to other places.

We, of course, had to deal with every kind of problem and do everything ourselves. None of our patients had private insurance. It was very difficult to get any of our patients into a hospital. Many times it seemed as if our patients became second-class patients when they were sent to other places, so we ended up doing everything possible ourselves. What it boiled down to was that if an unfamiliar medical problem came in, we would have to do the groundwork, read everything we could, possibly call a specialist and get advice, and

then take care of it ourselves as best we could. Little by little, our staff became very good at taking care of all kinds of illnesses.

When I was the only doctor there, the paramedical people would take care of all the routine things: viral infections, prenatal and postpartum visits, hypertension, and routine fractures. They would put on casts and sew up lacerations. They even got used to caring for many of the complex problems such as valley fever and tuberculosis, and many times they would handle the entire case and would only have to come to me for an occasional question.

Of course, we did have to refer patients for very special things such as open-heart surgery or premature babies that were sick. We became very good at knowing which hospitals and universities were interested in which kinds of cases and how we could get people through the front door and into the hospital. We often had cases spread out all over the state of California, getting specialized care in the various universities. For example, we might have somebody at the University of California in San Francisco getting renal dialysis; someone else would be at UC Davis getting radical neck surgery, and someone else down at the University of Southern California was getting a GYN cancer irradiated. Little by little, we made contacts with all of the universities in the state, and we always were able to get things done when we had to. Many times someone from our clinic staff would have to take the patient, get into the car, and drive down to one of these universities and make sure that everything happened. But in this way we got miraculous things done for people who were very, very sick.

It was very interesting how specialists would respond to our patients. Many specialists helped us because politically they agreed with what we were doing. Other times, when we had a specialized case, we would go through the literature and find out who wrote the papers that seemed to make the most sense and if they were anywhere near California, we would call them up, and invariably they would be very cooperative. They would do so just because they respected us medically and respected what we were doing, even though politically they may have not have agreed with what we were doing. Many of these specialists actually came to our clinic and helped us with difficult cases. Of course, this kind of personal relationship with the specialist made it much easier for us to deal with them later.

On the average, once a month we would have some sort of specialist come to our clinic and we would spend either half a day or an entire day seeing special cases in his area of concern. He would not only teach our staff how to deal with these cases, but many times he would accept these patients into his hospital for whatever kind of work was needed. In this way, we became more proficient and were able to take care of more things ourselves. We also developed a relationship with that specialist so that it was easy, with a phone call, to get advice on other cases.

One of the most important aspects of the functioning of our clinic was the issue of staff unity. It was very important to keep the staff highly motivated. Everyone was a volunteer; no one was getting rich at the clinic. Almost everyone's reason for being there was political. Any time conflict started among the clinic staff, this was immediately reflected in a worsening of the quality of care we provided. We tried to have weekly staff meetings, although at times we couldn't do this. Our agenda at these meetings would always be patient care problems and how we could improve. Second, we discussed staff problems and staff relationships with each other and fulfilling staff needs. Thirdly, we discussed union news. Finally, we discussed miscellaneous problems and usually a "case of the week" presentation, which was a special case that we had worked on the previous week and usually one that turned out real well. I think this was very important for building staff morale. Many times we were so busy that various members of the staff wouldn't even know what was going on among other groups. I think these staff meetings were very important. During the times that we didn't have these meetings, I myself felt less motivated, and I am sure that it took away from our overall effectiveness at the clinic. It took a lot of energy to get these meetings to happen. Someone had to plan it and get the agenda together, and then people had to attend and be there on time. Actually, we never did get a system worked out where these meetings would happen automatically. I struggled with this constantly and still don't know the answer to this problem.

The clinic itself had other bureaucratic problems, which I think all clinics have. There was the problem of hierarchy, who bosses whom, and who makes decisions in the various parts of the clinic. There were other questions such as "Is the clinic democratic enough?" "Is patient participation in how the clinic runs actually a reality?" or "How can we keep all the staff happy and still maintain our primary focus on patient care?" These kinds of problems were a day-to-day battle, and trying to deal with these things for six years made me understand that there is no simple answer. You have to constantly reexamine the things that are going on and try to deal with them. Overall, the experience for me as a doctor in the clinic was unique and very rewarding. We were dealing with people at the bottom of the socioeconomic ladder. We dealt with people from all over the world with medical problems that are rarely seen in this country. Yet we had the facilities to deal with these problems and give quality care. We had access to the best specialists and, if needed, the most sophisticated kind of medical care. There was constant pressure on us to take care of everything ourselves. We only used this kind of sophisticated care as a last resort when it was absolutely indicated. For this reason, we became very proficient at many, many kinds of medical functions. I myself became quite aggressive and instead of being afraid of certain kinds of illnesses, I would go out of my way to grab someone with a difficult problem and try to take care of him. If I ran into somebody on the street or in the waiting room who looked like they were very sick, I would go right up to them and start talking to them and try to find out what kind of problem they had and approach it with the confidence that I could do as good a job as anyone in taking care of this problem. I tried to get all the staff to think this way, and I think I was quite successful.

Some of the cases we dealt with turned out unbelievably well and were very rewarding to our staff. We worked very, very hard, and everyone on the staff was busy all the time. For the last three years, I was on call 24 hours a day, seven days a week, and had only an occasional day off. The average day for me started around 8 a.m. when I would either have surgery at the hospital or would make rounds. By 9 a.m. I would be out at the clinic. Many times I would have to start seeing patients in the parking lot outside the clinic when I would be approached by someone with a problem. From the minute I got into the clinic until the minute I got out, things were very hectic. Many times the clinic was close to chaos, but yet we always seemed to be able to deal with whatever was happening. We had seven examining rooms and it seemed like I would literally run from room to room. I dealt mostly with the very complicated cases. I was very good at delegating responsibility. Anything that I felt someone else could do, I would give instructions on and let them follow through. Usually I would start in the doctor's office in the morning and have a cup of coffee as fast as I could drink it. The radio was always pretty loud with rock-and-roll music. Then I would start going from room to room. I would write on the charts as I was talking to the patient and examining the patient. That way I wouldn't forget what was going on. As I walked the 5 feet from room to room, I would consult with the paramedical people on their cases and give instructions to them. There were always phone calls from various doctors. Often, fast trips had to be made to the hospital in between clinic patients for a delivery or some sort of operation, or there would be emergencies in the ER in the back of the clinic. At certain times it seemed as if I would have no choice but to run right over anyone in my way, because I couldn't spare a second to walk around them. This is hard to believe, but I used to kick doors open to get into the examining room. I developed a special technique of holding the door with my hand and then using my right foot to push the door open because I never had time to let it swing open slowly. With that technique I could control the door really well and stop it with my hand while I was kicking it open with my foot. The only complication was a couple of times there were little kids playing behind the door, and I think I scared them. But I never really hurt anyone with that technique. I did go through a lot of coffee although I didn't enjoy it. I just did it out of habit and to keep myself going.

We had as many as 180 patients in an eight-hour period and many times the work would carry on until late in the night. There were always emergencies after hours, but I did have the paramedical people well enough trained that they could take care of almost any emergency. As long as things were in the clinic, I could get someone else to take care of it. But in the hospital, our American system dictated that I had to do everything myself because I was the M.D. This was a major disadvantage.

For several years we did all of the deliveries in the clinic and then kept moms and babies there for four to six hours after the birth. We then followed them at home with our outreach people. Eventually, this filled up our clinic to such an extent that we had to switch that to doing deliveries at the hospital. One night I did deliver twins in the clinic and that was a big thrill. My own son was born at the clinic. One month I remember we had 46 deliveries.

We also had to find time for teaching. I developed my own little system of giving short talks on all the various topics. We also had to go over laboratory results, and make sure people were learning how to do the laboratory procedures and to take x-rays. I had to read the x-rays and taught other staff how to read x-rays. The same went for electrocardiograms. I really enjoyed teaching and seeing people function with a minimal formal education. It was also very rewarding for me to have medical students around, and it was stimulating for our staff.

As far as what our clinic accomplished, during this six-year period we saw approximately 150,000 patients. There were 1500 babies born. Millions of dollars were saved. Many, many lives were saved. Politically, we contributed as much as any other factor to the success of the union.

While I was at the clinic, I had many dreams as to what more could be accomplished. Of course, I wanted to see clinics everywhere for all farmworkers, doing more or less the same things that we were doing at our clinic. I also strongly believed that the delivery of health care in order to be more meaningful had to be done by people who were close to patients. One of my ideas was to have people on the job. For instance, one person from each ranch would be elected as the health liaison. This person would be paid by the employer for time spent developing health skills and also for becoming an expert at dealing with the health delivery system here in this country. This person could then be approached by any worker on that ranch and could do whatever possible either to help that worker himself or to guide the worker into the proper medical channel so that he could get proper care. Little by little this health liaison person could become more and more efficient and could become more and more skilled. The dream was that all this would be included as a provision of a labor contract and become part of the master plan for the union on each ranch where it had contracts. Maybe someday it will still happen.

When I left the clinic in December of 1977, the clinic was closed. There were many reasons for this. The union, of course, believed that the clinic was primarily an organizing tool. Over the six years that the clinic existed in Delano, farmworkers gradually became better off than they were previously. Many of them now had health insurance. It wasn't comprehensive coverage, but it was enough to get them into a hospital if they needed to go. Wages were better. Job security was better. Living conditions were improved. Through new laws and better contracts, workers didn't have to migrate as much. Battles were fought in courts and not on the streets. In general, farmworkers became more established. The better off farmworkers got socially and economically, the less political motivation there was to continue doing the kind of work we were doing at the clinic. The union also was not as committed to continuing in health care. Their priorities were getting contracts and enforcing contracts, and running clinics detracted from this primary priority.

It was difficult to get doctors to come to the clinic. Part of the reason was that it was in a rural area away from the big medical centers. The pay was nonexistent. The work was

difficult. Doctors were not as politically motivated as they were during the Vietnam era, and the actual political motivation had diminished in the union struggle. One of the most significant factors was the hard-line attitude of the union leadership, Cesar's in particular. As the union grew, Cesar became more and more incapable of delegating responsibility. He was very possessive about the union and undoubtedly no one else could have done what he did in getting the union to where it was. This led to him making decisions without having the time to become adequately informed. Moreover, when anyone disagreed with these decisions, there was no mechanism by which they could have a discussion and possibly get an explanation for how things were decided. More and more people were told not to question anything and to do just what they were told. In the end this attitude made it almost impossible to function in the clinic.

Every day we had to make very difficult decisions about patient care and the functioning of the clinic. Even though we did this, we were told that we were not to be involved in any of the administrative decisions about the clinic. In fact, many of these decisions were never made, and that brought the clinic slowly to a grinding halt.

One of my failures was that I didn't know how to deal with this problem effectively. First of all, it was very hard for me to pinpoint in my own mind why things were going the way they were towards the end. When I finally decided that it boiled down to Cesar Chavez and his leadership, I was unable to communicate with him and try to set up a plan for changing the way things were going. In large part because of this, I decided to leave the clinic. Cesar was becoming increasingly paranoid and distrustful of anyone. He was unable to get close to anyone and made many—to my mind anyway—irrational decisions. While it was almost certainly true that the FBI and possibly even the CIA had infiltrated the union, this can not begin to explain why certain actions were taken.

All in all, my experience at the clinic was by far the most significant activity of my life. It was through my experience at the clinic that I matured medically and also politically. I also became aware of the many complicated problems that one runs into in trying to keep an entity of this nature functioning. Hopefully, this experience will help me in my future work, wherever that may be.