

# Tin-Cup Medicine

*Resourcefulness, patience, and a willingness to beg are key to practicing medicine on the “safety net.”*

BY FITZHUGH MULLAN

SHIRLEY LAOTSI IS A PATIENT OF MINE—a big, shy, affable girl who arrived in Washington, D.C., from central Africa two years ago with her refugee parents. Shirley shows no external scars from the long and dangerous journey that took her through several African countries and across the Atlantic. She is in school, has friends, loves television, and is growing well—too well. Although she has just celebrated her eighth birthday, she shows signs of advancing puberty and has grown quickly to the height and weight of an average twelve-year-old. This pattern of growth is problematic and raises concerns about tumors or endocrine diseases. Even if these possibilities are ruled out, Shirley faces a heightened risk of diabetes and likely social problems. Her rapid growth calls for a series of hormone tests, x-rays, ultrasounds, and a consultation with an endocrine specialist. Lacking work permits, jobs, and medical insurance, the Laotsis have relied on whatever charitable or governmental services are available. They get their medical care at the Upper Cardozo Community Health Center, where I work.

Upper Cardozo is a spacious, unattractive, four-story bunker constructed in the early 1970s when the federal Community Health Center (CHC) program was still building clinical facilities. An African American neighborhood at that time, today the community is heavily El Salvadoran with a mix of other Latino groups, Vietnamese, Africans, and African Americans. Refugees from a variety of nations seek care at our clinic because of its open-door policy and sliding fee scale. The clinic runs special programs for food (WIC), HIV/AIDS, the homeless, and social services. Staff members speak English, Spanish, Vietnamese, Chinese, French, and Amharic. About a third of our patients have Medicaid. The rest, with few exceptions, have subsistence employment at best, no health insurance, and few

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financial reserves to cover medical costs.

Upper Cardozo is a strand—a thick cord, actually, compared with many of the filaments that make up the amalgam of health care possibilities for the poor and uninsured that we have come to call the “safety net.” Upper Cardozo is one of about a thousand community clinics that make ends meet with funds provided annually by the federal CHC program, smaller public and private grants, Medicaid reimbursements, and the tin cup. By the tin cup, I don’t mean charity events and fundraisers (although they have a potential role)

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but, rather, the perpetual, frustrating, quixotic, creative, and demeaning process of begging for services from others for our patients.

We needed the tin cup for Shirley. Upper Cardozo provided her with a pediatrician, some basic blood tests, and the diagnosis of precocious puberty. But then we needed help: special tests and a specialty consultation. A local hospital offers free consultations to a limited number of uninsured patients from health centers such as ours. Our social worker helped the family fill out the many forms required by the hospital; I called the endocrine department myself to make her the appointment. A week later I received a distress call from Shirley’s father on a pay phone reporting that the hospital required a down payment of \$200 before Shirley could be seen. I then spent twenty minutes talking to voice mail and an occasional person at the hospital clinic, the finance office, and the president’s office—which resulted in Shirley’s being seen that morning without a deposit. The endocrinologist was good enough to call me with her findings that Shirley’s growth was probably a normal variant not caused by a tumor. But the doctor wanted to see her back after more tests, presaging another round of tin-cup challenges.

### The Limits Of What We Can Do Alone

RESIDENT BUSH HAS HAD KIND THINGS TO SAY about CHCs, and his 2002 budget proposes increased health center funding. I applaud this initiative, but if he thinks that a few more health centers will fix the safety net, he underestimates the problems. CHCs bring crucial facilities to poor neighborhoods; they bring doctors, nurses, primary care, and urgent care. Since their introduction as part of the War on Poverty thirty-five years ago, they have been central to serving the poor and uninsured. What we

do at Upper Cardozo is first rate. We provide basic medical treatments and preventive services and do it in a way that is, for the most part, creative and responsive to the community. In pediatrics we talk the patients' languages. We provide them with immunizations, lead poisoning and anemia screening, two children's books per visit, occasional home visits, and a special clinic for teenagers. Trouble develops, however, as soon as something more is needed—something as simple as a medication or an x-ray. Things quickly get more difficult if we need a specialty consultation, a nonroutine diagnostic procedure, surgery, or hospitalization.

For the minority of our patients who have Medicaid, the problems resolve themselves quickly and usually satisfactorily. Medicaid (even managed Medicaid, which is predominant at Cardozo) covers medications, diagnostic tests, and the costs of specialists and hospitalizations. But for the two-thirds of our patients without Medicaid, the only answer is the tin cup. This means resorting to charity services, give-away programs, personal connections, system loopholes, solicited forbearance, and persuasion.

### Getting Vangie Her Due

VANGIE THOMAS SHOULD HAVE HAD MEDICAID but didn't. A sullen, pretty five-year-old, she arrived in the clinic one day with her foster mother and a case of ringworm—a skin infection easily treated with about twenty dollars' worth of medication. Her foster mother, Mrs. McCarthy, an elderly woman with four other foster children, handed me a folder with the official papers accumulated over six months of caring for Vangie. It contained an array of forms, documents, and stubs from several government and intermediary child protective organizations. The central document, as far as I could tell, transferring Vangie to Mrs. McCarthy, was only partially filled out, in longhand, and listed Vangie's names as "Vangie," "Angie," "Thomas," "Promis," and "Thoms." I was satisfied that my little patient's name was, in fact, Vangie Thomas, because the file did contain a photocopy of her Social Security card. What it did not contain was a Medicaid card or any reference to Medicaid.

What kind of system, I asked myself, turned a child over to a foster mother with five versions of her name and no Medicaid card? I began by calling a name and number scribbled on a piece of paper that Mrs. McCarthy told me was her caseworker. Three voice-mail messages and two agencies later, I reached a human being who acknowledged that as a foster care child, Vangie should have Medic-

aid and agreed to start the process. She assured me that the card would be retroactive. But that would be of no use at the pharmacy that morning. Fortunately, we had a tube of the antifungal medicine Vangie needed and gave it to her. When Vangie returned for a follow-up visit, her infection was improving, and a call to the case-worker produced a Medicaid number—although the worker said she had “no idea” when the actual card might arrive. Happily, the number did work at the local pharmacy for her medication refill, but Vangie would have to be counted as partially insured, a beneficiary of the Medicaid system when and if the multiple agents of child welfare were at their desks and engaged. Banging the tin cup succeeded in getting Vangie tentatively into the system.

### An Island Of Security

THE MORE SEVERE THE PROBLEMS or the larger the family, the more important Medicaid becomes. At the end of a rainy morning, Mrs. Castro arrived at the clinic with five sets of school immunization forms, one for each of her school-age children. She had four younger ones at home. I knew the Castros well, although I never could keep the children sorted out. They were a blur of illnesses in the clinic, in the hospital, in strollers, on foot, under foot. We had hospitalized one or another for asthma, diarrhea, and pneumonia. We had treated others in the clinic for rat bite, speech delays, ear infections, anemia, and scores of immunizations.

With the children’s charts and the help of a nurse, I filled in the immunization records five times over, the sort of repetitious task that must occupy most of Mrs. Castro’s waking hours. At the lunch hour, when we were done, I drove Mrs. Castro home to an apartment that consisted of a corridor that ran the length of the narrow basement of a row house, ending in a kitchen at the back. The apartment walls were bare, the linoleum threadbare, and the cockroaches defiant. School was closed because of a storm warning, and all nine children were milling around, with Mr. Castro as babysitter. When we entered, the younger children ran off with my stethoscope while the older ones showed off gymnastics on the bunk beds. After a brief chat with Mr. Castro, I collected my stethoscope, picked my way through playful children, and retreated to the car.

Life in the Castro family was a sea of chaos in the middle of which was an island of security. Despite poverty and the challenges of a large family, I never needed to use the tin cup for the Castros. The family had health insurance that covered every clinic visit, medica-

tion, hospitalization, and consultation. They had Medicaid.

Because of Medicaid, we have the luxury of using the tin cup a bit less in pediatrics than do our colleagues who work with adults. Underfunded as it might be, and unpopular as it is in some quarters of the medical profession, Medicaid connects a patient to medications, diagnostic tests, consultants, and hospitals in a way the tin cup never can. The advent of the State Children's Health Insurance Program (SCHIP), in particular, has made Medicaid more available to low-income children. Little by little many more of the kids I see are getting enrolled, although immigrants, refugees, older children, children from disorganized families, and parents still don't get covered. Enrollment can be slow, bureaucratic, and temporary, but Medicaid makes a huge difference in what I can do for children.

### Rattling The Tin Cup For The Rest

WITHOUT MEDICAID, THE TIN CUP COMES OUT as soon as we reach the limits of what we can personally do for the uninsured patient at a health center—the child with a fever and cough who needs a chest x-ray, the diabetic who needs insulin, the teenager with depression who needs Prozac, or the four-year-old with garbled language who needs speech therapy. The telephone figures prominently in tin-cup medicine. I call local agencies

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to find charitable funds for medications, I call for special openings for speech therapy or mental health exams, I phone specialists or dentists who might see a patient for free. I also write letters: to schools pleading for special education placement, to drug companies begging for medications, or to other physicians asking for opinions. Some days I spend as much time pleading as I do practicing.

Medications are the most predictable and frequent stumbling block in a safety-net practice. Dignity, trust, and momentary circumstance all come into play at the end of an office visit when I ask an uninsured patient if she thinks she can afford the prescription I have just written. I never know exactly what the medication will cost, but I can be sure that it will severely tax a small budget. The clinic purchases and distributes a small supply of basic medications in emergency situations. We also have some samples to distribute, although they rarely meet the need for the precise medication indicated, nor are they available in adequate quantity. Drug company representatives are infrequent visitors to our clinic.

These tin-cup problems are compounded for those who care for adults. Lives can be improved and saved with well-established, relatively inexpensive treatments for chronic, common conditions such as heart disease, thyroid disease, diabetes, and hypertension. The treatments, though, have to be as chronic and persistent as the diseases. Yet since so few adults at Upper Cardozo have any coverage for medications or referrals, the tin cup—with all of its inadequacies—is always in play and rarely sufficient.

### Retiring The Outstretched Palm

**M**EDICAID AND COMMUNITY HEALTH CENTERS are complementary strands of the safety net, running across and reinforcing each other, making the net stronger and more durable. CHCs are extraordinary institutions that provide service to people in need and represent our civility as a society. They put a front line of doctors, nurses, and social workers in communities where they would not otherwise be. But they can't do the job alone. Insurance coverage is a must for a patient to be able to buy his or her way into the rest of the health care system. Medicaid provides that access for health center patients who are fortunate enough to have it. But what about the majority at our clinic, who don't? The tin cup is archaic and inefficient. Expanded coverage for children under SCHIP dramatizes what can be done. Extending coverage to SCHIP parents has been proposed, as have other Medicaid expansions. Lowering the age of Medicare eligibility has been considered in the past as a method of closing the gap for the uninsured, as has a mandate to employers to provide private insurance.

As a tin-cup provider, I salute the president's support for CHCs. But I want to know where he intends to go from here. As he contemplates costly strategies such as doubling the budget of the National Institutes of Health or providing a prescription drug benefit to Medicare recipients, he needs to reflect on fairness in America. If we are serious about putting a floor and not just a net under health care, we will need both more CHCs and expanded insurance coverage to close the health care gap between the poor and the rest of us.

We need to retire the tin cup as soon as possible.

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