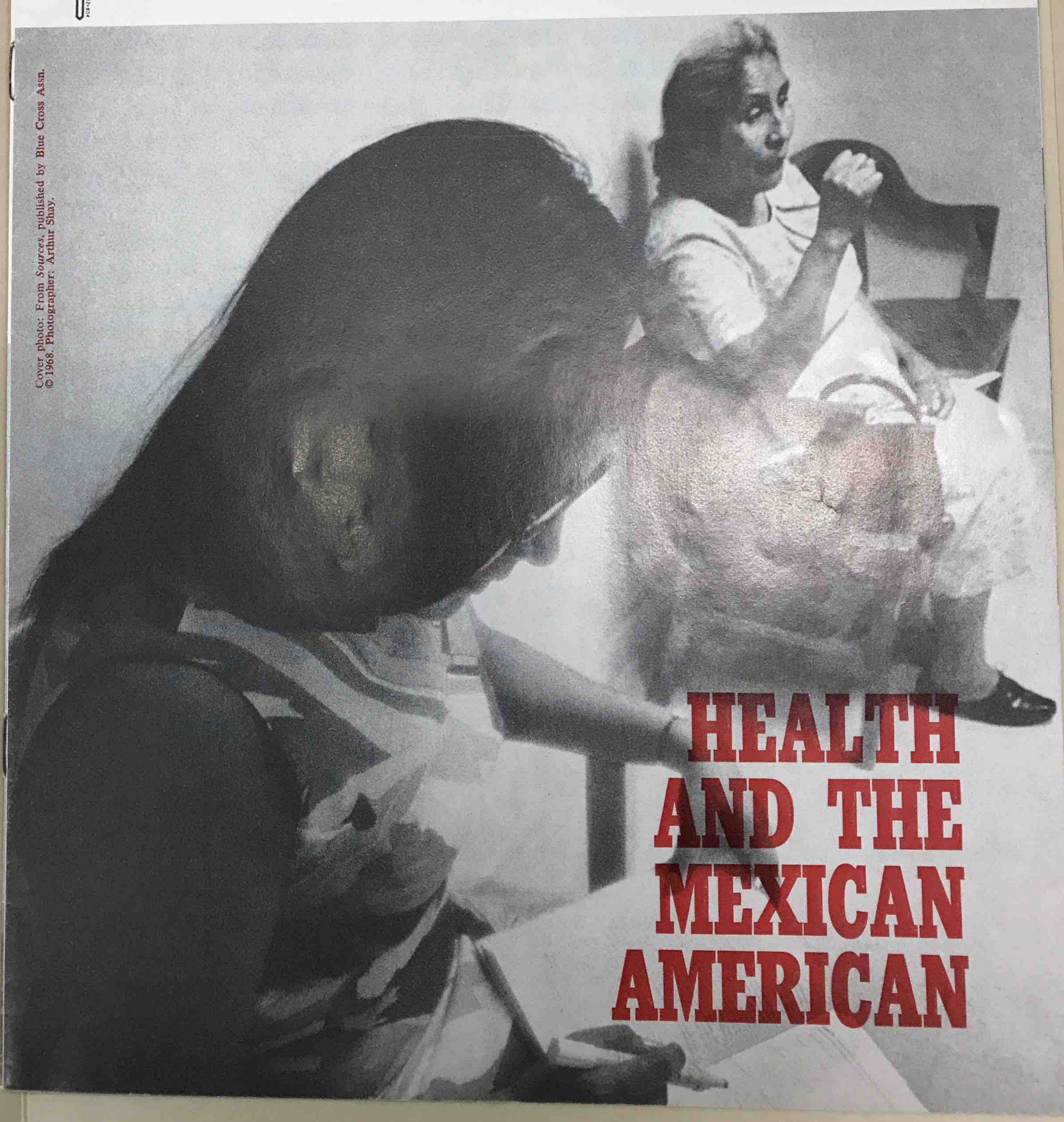
APRIL 1973

Bulletin

NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION



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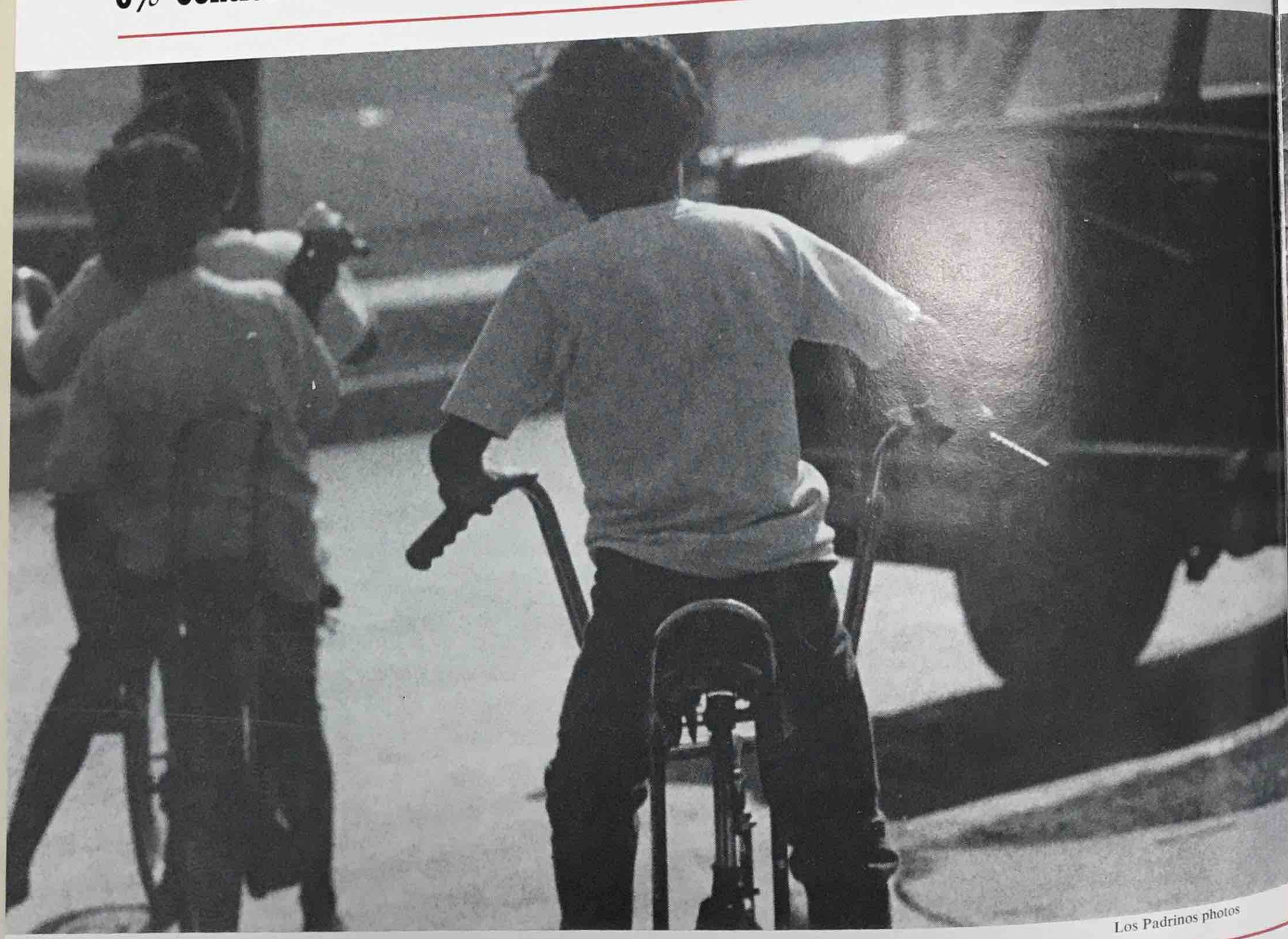
HEALTH AND THE MEXICAN AMERICAN

THE MEXICAN AMERICAN:

Henry M. Ramirez

The Census Bureau tabulates 9 million Spanish Americans in the United States. Of these, 57% are of Mexican origin; 17% Puerto Rican; 7% Cuban; 6% Central and South American and 13% "other Spanish origin."



Los Padrinos photos

ABOUT THE TERM "MEXICAN AMERICAN". No single term is preferred by all the people who proudly trace their ancestry to Mexico. Some prefer to be called "Spanish American," "Spanish speaking," "Chicano," or "Mexicano," among others. There are differences in meaning among these. The Anglo should listen before he labels, remembering also that some prefer to be known simply as "Americans."

NTRDA Bulletin

A PROFILE

Adapted from an article in *El Hispano*

The 5 million Mexican Americans make up one of the least understood minority groups in the United States. Proud, talented, and industrious, they face many problems, including disease.

Los Padrinos, Pasadena, Calif.

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WHO ARE the Mexican Americans?

They reside in every state in the Union.

They represent roughly 5 million of the U.S. population, making them our second largest minority group. Physicians, dentists, lawyers, and prosperous businessmen are numbered among them, but far too many are poorly paid laborers. Some speak only Spanish, others only English, and many speak both languages.

Despite their numbers, the Mexican Americans have only recently begun to capture the attention of the general public. The national news media during the past decade have become aware of this significant minority but have continued to reinforce a mixed-to-negative picture of them as rural, lazy, sinister, illiterate, and culturally disadvantaged. The Mexican Americans resent these stereotypes. Though they have dwelled in territory now part of the U.S. for centuries, they are too often regarded as interlopers and not part of the American mainstream.

In general, Mexican Americans are severely disadvantaged compared with the dominant Anglo population. In income, occupational status, and unemployment, their status is roughly equivalent to blacks; in education they are far worse off. Discrimination against them remains a major obstacle to their social and economic progress. Lack of English facility and other cultural differences, including a partially self-imposed ethnic isolation common to earlier generations of immigrants, leave a great many Spanish-surnamed people outside the mainstream of economic opportunity.

Numbers have increased substantially

Since World War II, the number of Mexican Americans has substantially increased, and they have tended to move from the country to the city and to disperse throughout the U.S.

The area with the highest concentration of the Spanish-speaking includes the southwestern states of Arizona, California, Colorado, New Mexico, and Texas, where the overwhelming majority of Mexican Americans are located. On the other hand, more live in Illinois than in New Mexico, Arizona, or Colorado. Almost 75,000 live in Detroit.

Most Mexican Americans were born in the U.S., and large numbers are ill-educated and otherwise disadvantaged. Except for New Mexico and a few locales in California and Texas, they have not reached positions of economic or political power.

Income is the best single determinant of economic and social status. Census figures for 1971 emphasize the inferior position of the Mexican American to the rest of the United States. Median family income in 1971 was $7,486 for the Mexican American and $10,285 for all Americans.

Most are in unskilled, low-paid jobs

Census figures show that some 29 percent of Mexican Americans are below the poverty level. The comparable figure for all Americans is 13 percent and for blacks 34 percent. Clearly, Mexican Americans are congregated along with blacks at the bottom of the economic ladder in terms of income.

The precarious economic position of the Mexican Americans is further underscored by the nature of the jobs they hold. About 70 percent of them are in unskilled and low-paid blue-collar, service, and farm jobs. Only 17.5 percent of Spanish-surnamed men hold white-collar jobs, compared with 42 percent for all American males.

Being relegated to the bottom of the economic heap is a consequence of the educational deprivation suffered by the Mexican Americans, as well as the discriminatory barriers they face along with other minorities. Only about one in four Mexican Americans 25 and older has completed high school.

A strong sense of cultural uniqueness

Somewhat less measurable but no less real are the cultural differences between the Mexican Americans and other Americans. The Mexican Americans have a strong sense of cultural uniqueness, coupled with feelings akin to outrage that the broader society has failed to recognize, accept, or even place a positive value on their contribution to the diverse fabric of American society. To some extent these felt cultural differences result in part from the high proportion of the Mexican Americans living in poverty. In this sense, they have characteristics in common with blacks, Appalachian whites, or others living in the "poverty subculture."

There are, however, very real differences between disadvantaged Mexican Americans and other poor Americans —differences that affect the conduct and success of manpower and other social programs. These differences include language, value orientation, ethnic-isolation, and other social and psychological factors.

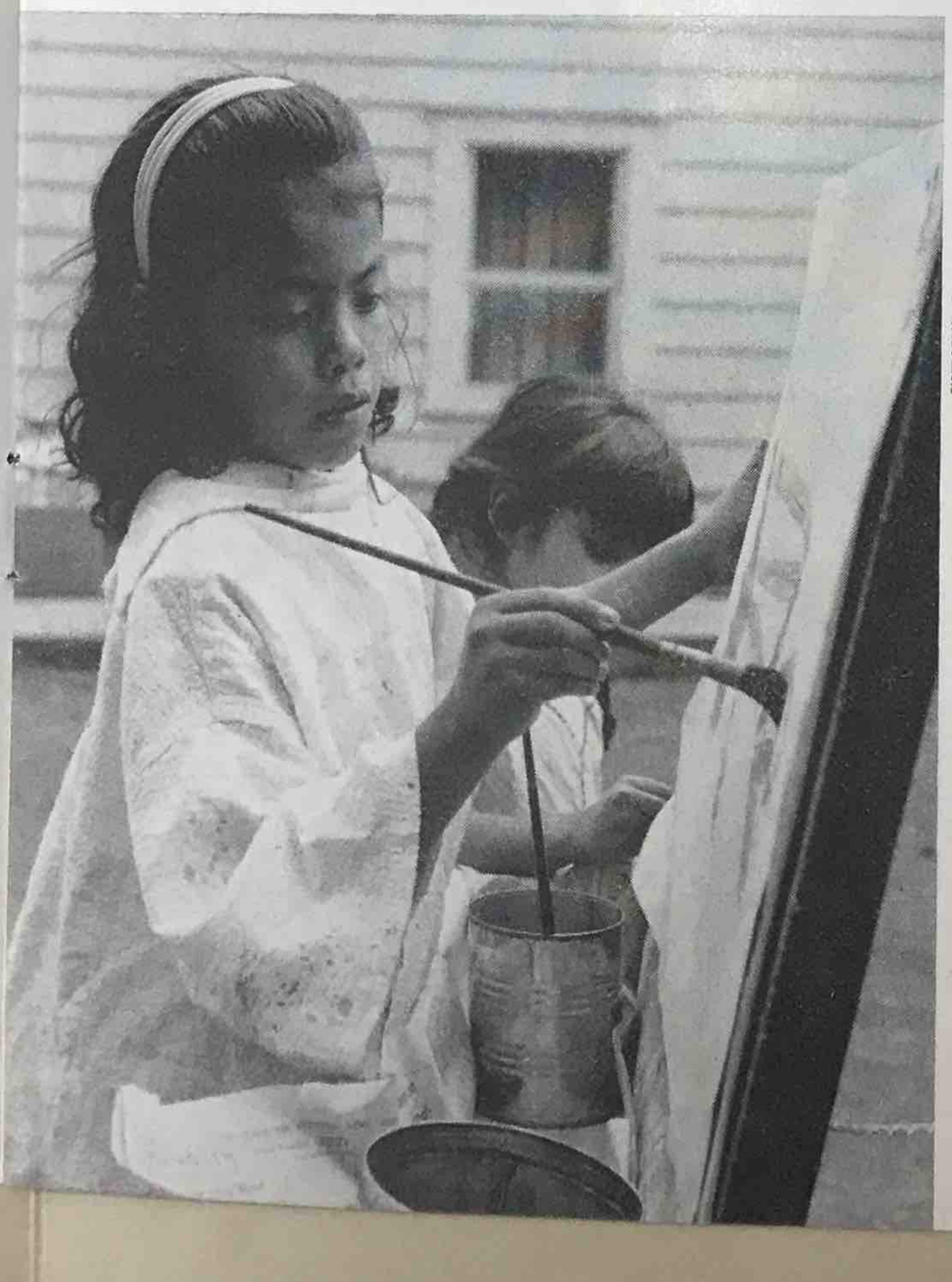
Spanish is the most prevalent of all foreign languages in this country and the one with the highest likelihood of surviving here on a permanent basis. Mexican Americans, unlike earlier waves of immigrants, persist in using their language over several generations. Access to Spanish-language mass media and entertainment permits this pattern to continue. Furthermore, the Spanish-speaking have fewer economic incentives to learn English because their opportunities to advance are limited and the acculturation pressures from children and the rest of society are less severe than in the past.

These language barriers and education problems go hand in hand; they feed upon and exacerbate one another. Efforts by manpower and education agencies to cope with language difficulties generally have been inadequate, both in quality and quantity, although recently there has been

Authenticated News International

The press too often stereotypes Mexican Americans as rural, illiterate, culturally disadvantaged.

Mexican Americans want training and education for themselves and their children, yes. But they also want to preserve their unique culture.



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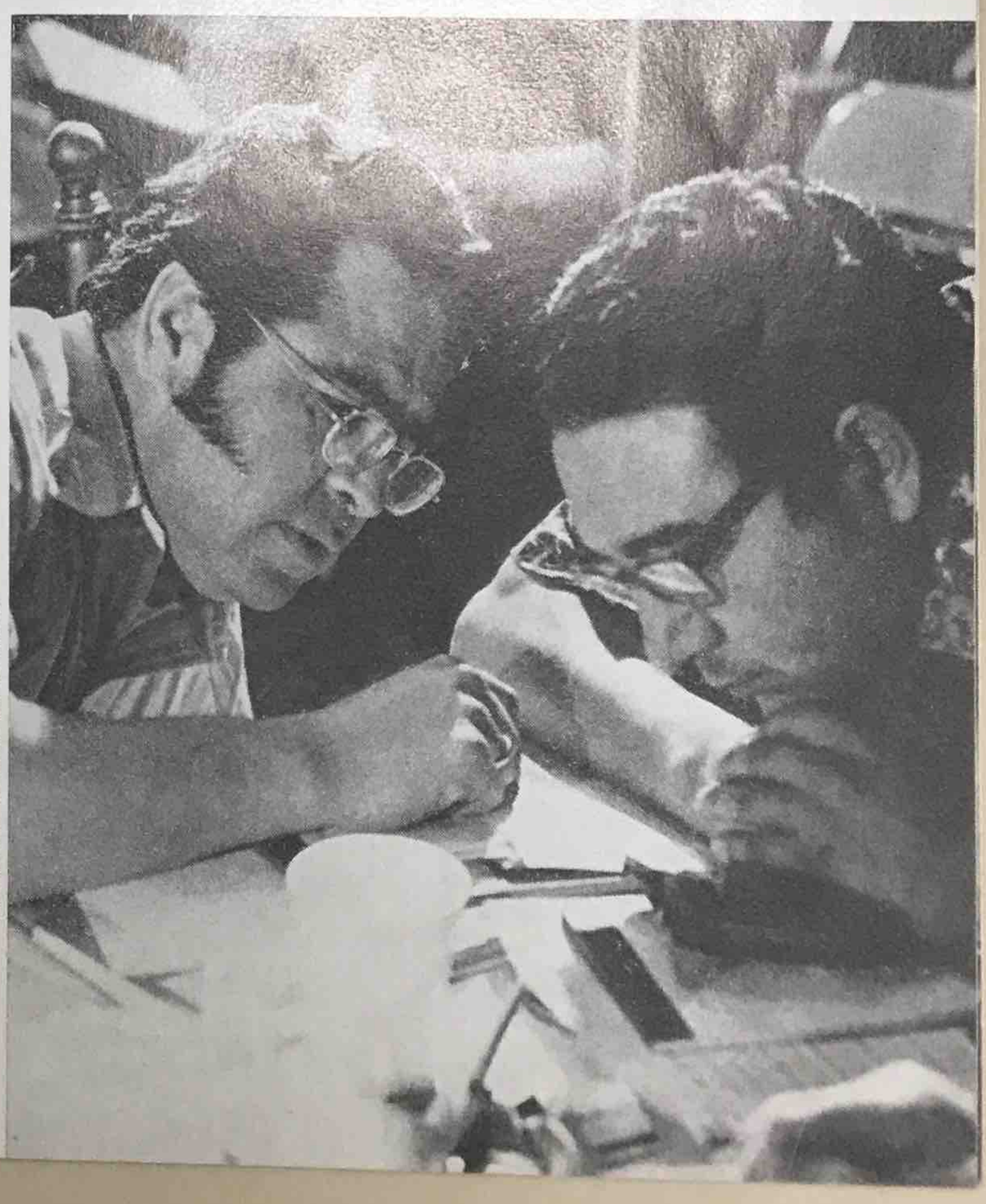
Mexican American leaders are also calling for development of skilled, Spanish-speaking policy-makers and managers.



Southwest Council of La Raza

East Los Angeles is now heavily Mexican American, as are sections of many other cities.

a commendable increase in emphasis on language training in manpower programs.

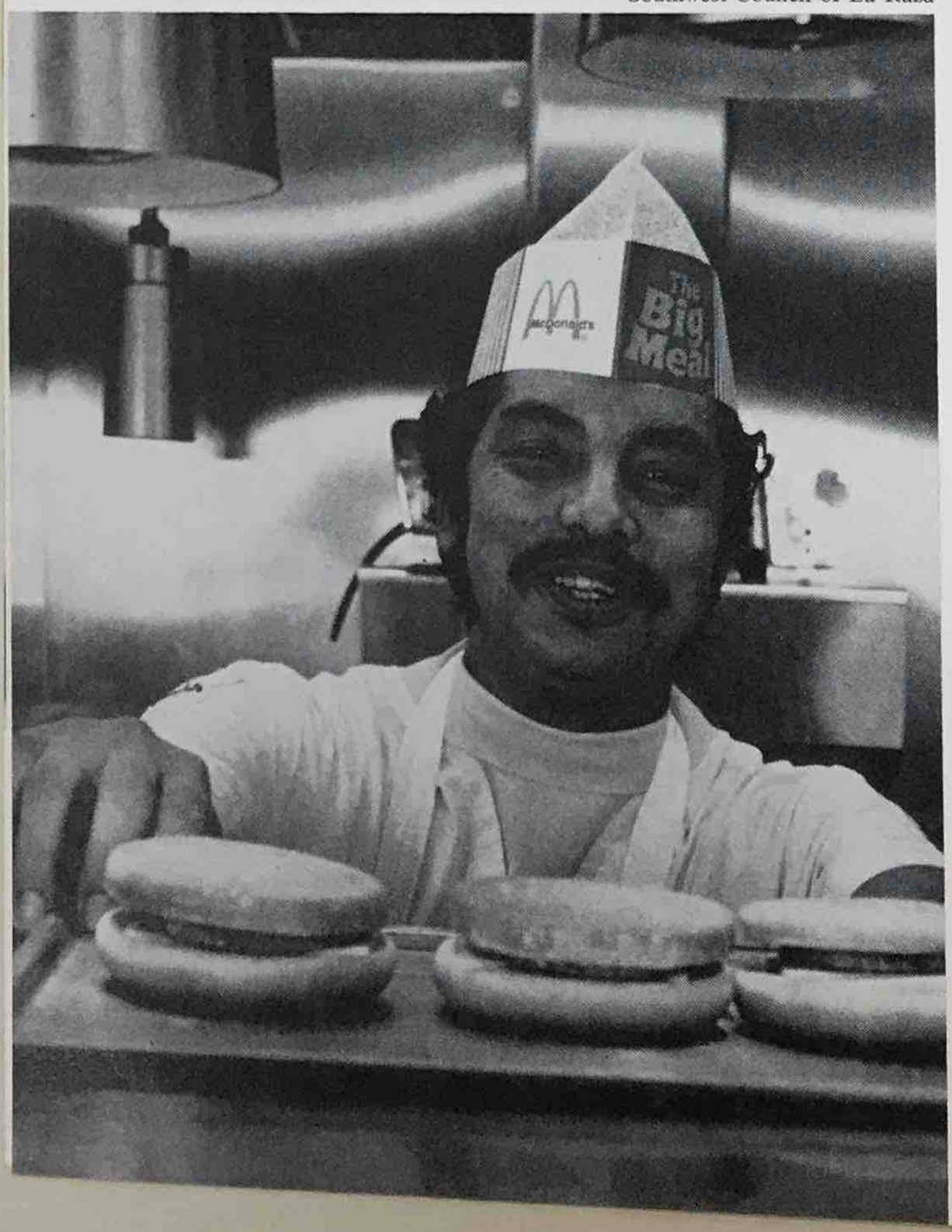
When it comes to a discussion of value orientations, the danger of stereotyping always is high. Value orientations often differ among the various groups of Mexican Americans as well as between them and other Americans. But some cultural attributes that seem to apply to most of the Mexican Americans can be readily identified:

- Relations between individuals are more important than competitive, materialistic, or achievement norms.
- Strong family ties.
- A sense of solidarity and pride in a unique heritage (a feeling sometimes referred to as La Raza).
- Aspirations for professional rather than business or managerial occupations.

To some extent these values reflect an older rural culture. As Mexican Americans move to the cities—80 percent now reside in urban areas—they tend to pick up Anglo values. The older values persist, however, and it would be unsafe to assume they will materially change in the present generation. Indeed, there is sharp disagreement within the Mexican American community on the necessity and value of assimilation. Efforts at forcing assimilation, such as the practice of some southwestern schools until recent years of forbidding children to speak Spanish, are generally recognized as unwise.

Mexican Americans work at all types of jobs. He's a counter man in the city.

Southwest Council of La Raza



And he works in the country at his trade of tanning hides.

Linda Bartlett, OEO

Marcia Kay Keegan, OEO

A boost for this southwestern Spanish-speaking community: a self-help housing project.

Ethnic isolation linked to rural background

The basically rural background of the Spanish-speaking helps to explain their ethnic isolation, an isolation more pronounced than that of earlier immigrants. Until World War II, they were congregated in rural areas and held farm jobs, while earlier generations of new Americans generally went to the cities where the pressures of the melting pot were greater. By the time the Mexican Americans began to urbanize, their numbers were great enough and their subculture strong enough to survive these pressures.

The overwhelming majority of the Mexican Americans live in self-contained neighborhoods separated from the rest of the community. Sometimes, this represents a choice of the individual who feels more comfortable in familiar surroundings with people of his own culture and background. All too often, unfortunately, the reason can be found in economic or social discrimination which forces the individual to live in substandard housing in an area having few public services. Such barrios are quite similar to black ghettos. Studies of metropolitan areas such as Los Angeles demonstrate that the chances of a Spanish-speaking person occupying substandard housing are over four times that for an Anglo at a similar income level.

The majority community must adjust

As Mexican Americans develop the skills to help themselves, the majority community must make some adjustments in meeting their needs. This is particularly true of institutions providing training and education in an attempt to help Mexican Americans improve their position in the economy.

Manpower policies and programs too often have failed to recognize and deal with the uniqueness of the manpower needs of Mexican Americans. The decision makers often do not know enough about the language and cultural characteristics of the people to develop viable and effective programs. The fact that Mexican Americans speak a foreign language and have different backgrounds is regarded as being their own problem, and the need to establish programs built upon serving people from different cultures is not always recognized.

As a result, while the basic idea of training and education for the disadvantaged may be sound, the policy for implementation has built-in deficiencies which retard success. There must be an urgent, full-scale effort to develop sufficient numbers of skilled Spanish-speaking policy-makers and managers and place them at all levels of the delivery system if manpower programs are to serve the Spanish-speaking effectively. Over the last few years substantial increases of funds have been granted to Spanish-speaking manpower delivery organizations, and this trend must be continued until equity has been achieved.

Giving jobs to the Spanish-speaking on the operational level as interviewers, counselors, trainers, and job developers is not enough. These people would be forced to perform two tasks, delivering services and sensitizing their superiors to the needs of the Spanish-surnamed. They could perform much more effectively if they were relieved of the second task—that is—if their superiors as well as their clients were drawn from the Spanish-speaking population.

The federal government's Department of Labor, in all fairness, has at least partially responded to this need. Its Manpower Administration has added many Spanish-speaking professionals to its top-level staff. But the number is still relatively slim, equity has by no means been achieved, and we cannot wait for Spanish-speaking counselors and interviewers to work their way up by the usual laborious routes. To overcome the effects of decades of discrimination by the society at large, extraordinary action must be taken now.

Mexican Americans want the opportunity to participate in society—to share, learn, and grow—as individuals and as a group. For many centuries they have been a simple and docile people. This will no longer be true as we move into the 1980's. As Americans, they expect to exercise their rights and responsibilities in the context of American society. «

HENRY M. RAMIREZ is chairman of the Cabinet Committee on Opportunities for Spanish Speaking People. He is a former migrant worker and a longtime civil rights activist and community leader. He joined the Cabinet Committee after serving the U.S. Commission on Civil Rights as director and chief of the Mexican American Studies Division.

OUR PROBLEM IS NOT THE DISEASE

Henry Guerra

THE ALAMO AREA TB-RD Association is one of the oldest in the state. It used to be the Bexar County TB Association. Now it's expanded to include some 20 counties. But the core of the local TB problem is still in San Antonio, one of the oldest cities of Texas.

Tuberculosis has always been a problem in San Antonio. In reading the old Spanish histories about the founding of the missions, you find that tuberculosis gave great concern way back in the mid-18th century. It hasn't changed today. And the greatest number of its victims here are still Spanish speaking.

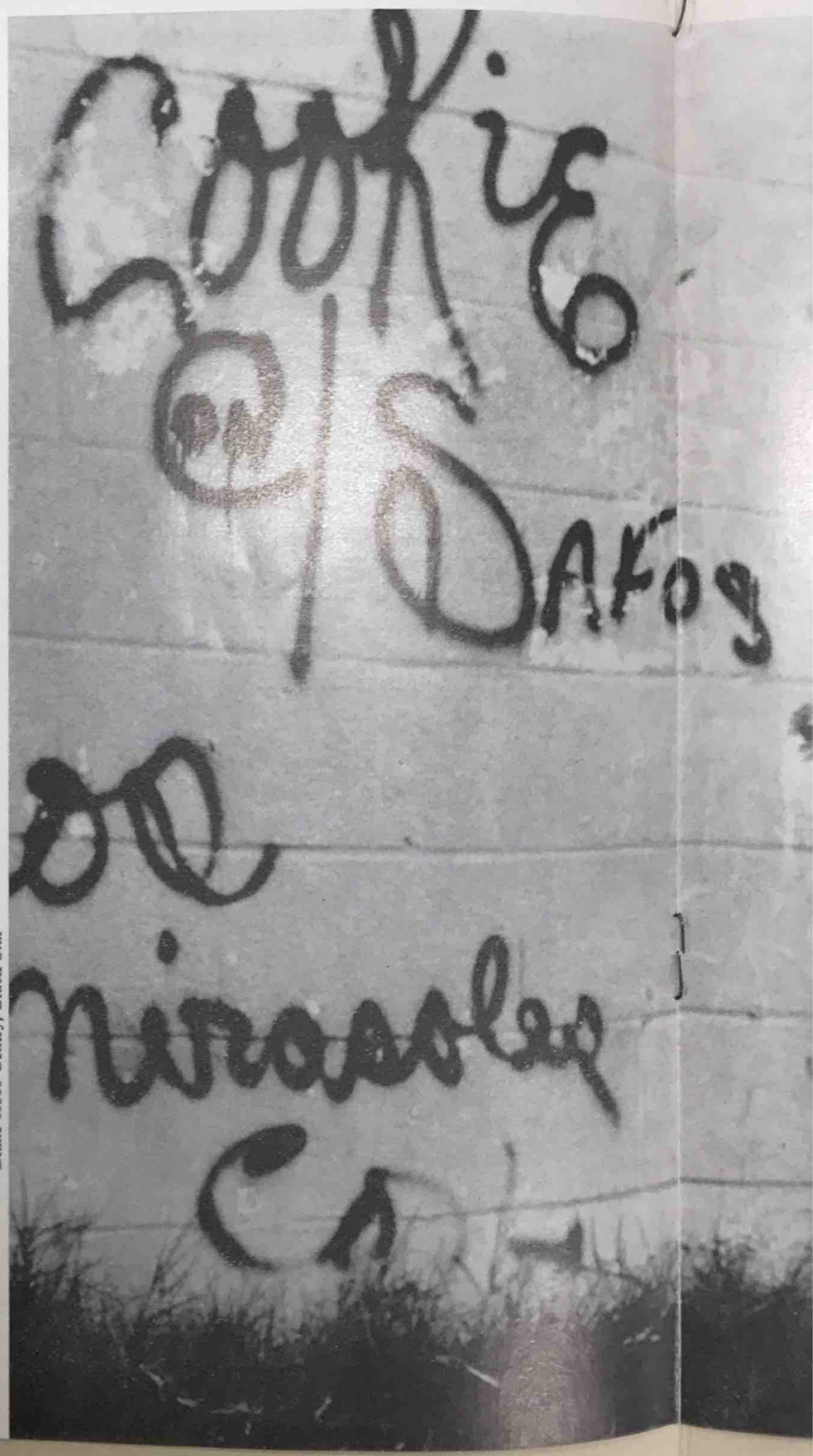
This despite the fact that a strong official state tuberculosis control agency services this area. And despite the fact that the Bexar County TB Association was formed back in the twenties, was active, had ongoing programs, had input from the Mexican American community. There have been Mexican Americans as board members and officers of the TB association for many years.

Reaching the Mexican American in the barrios

Nonetheless, we've never really solved the problem of how to reach the average Mexican American living in the barrios. And unfortunately the bulk of our Mexican American population still live in those poverty areas, despite many individual success stories.

For years we used to send out the old X-ray machine, well publicized in advance, using the Spanish-language radio stations and later the Spanish-language TV station, using Spanish-language printed materials, working with community leaders who themselves were Mexican Americans. The drums were beaten and by the best techniques known. And yet we couldn't get the Mexican American people in the barrios to come directly to grips with the TB burden they carry.

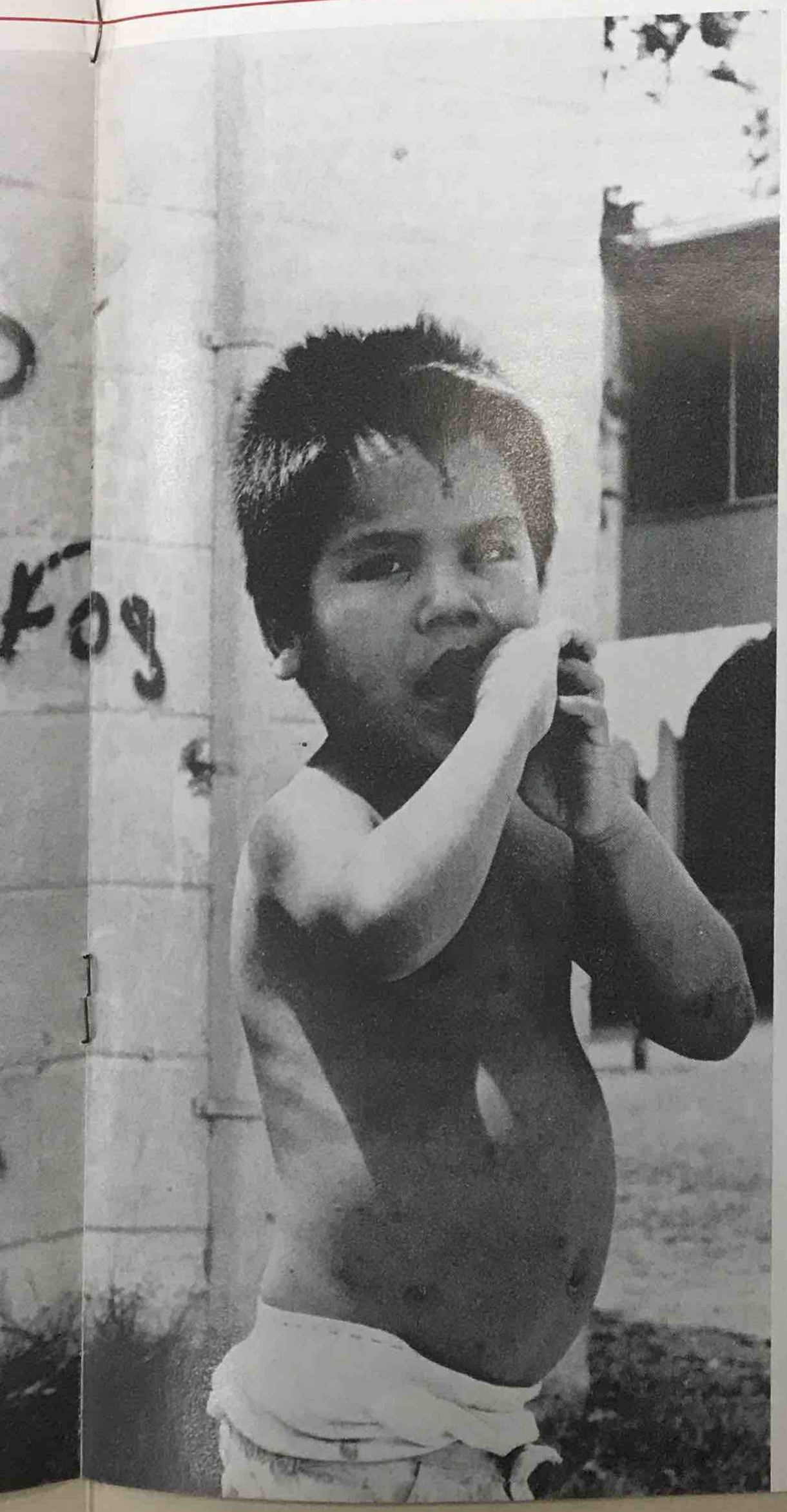
One reason for the failure may very well have been a weakness in communication by the predominantly Anglo public health officials who operated in this area. They lacked empathy, perhaps, with their consumer clients. Nonetheless, there has been progress even in this area.



Diane Koos Gentry, Black Star

This boy lives in a public housing project, Mirasol Homes, in San Antonio. The words on the wall are "Tex-Mex," the local dialect.

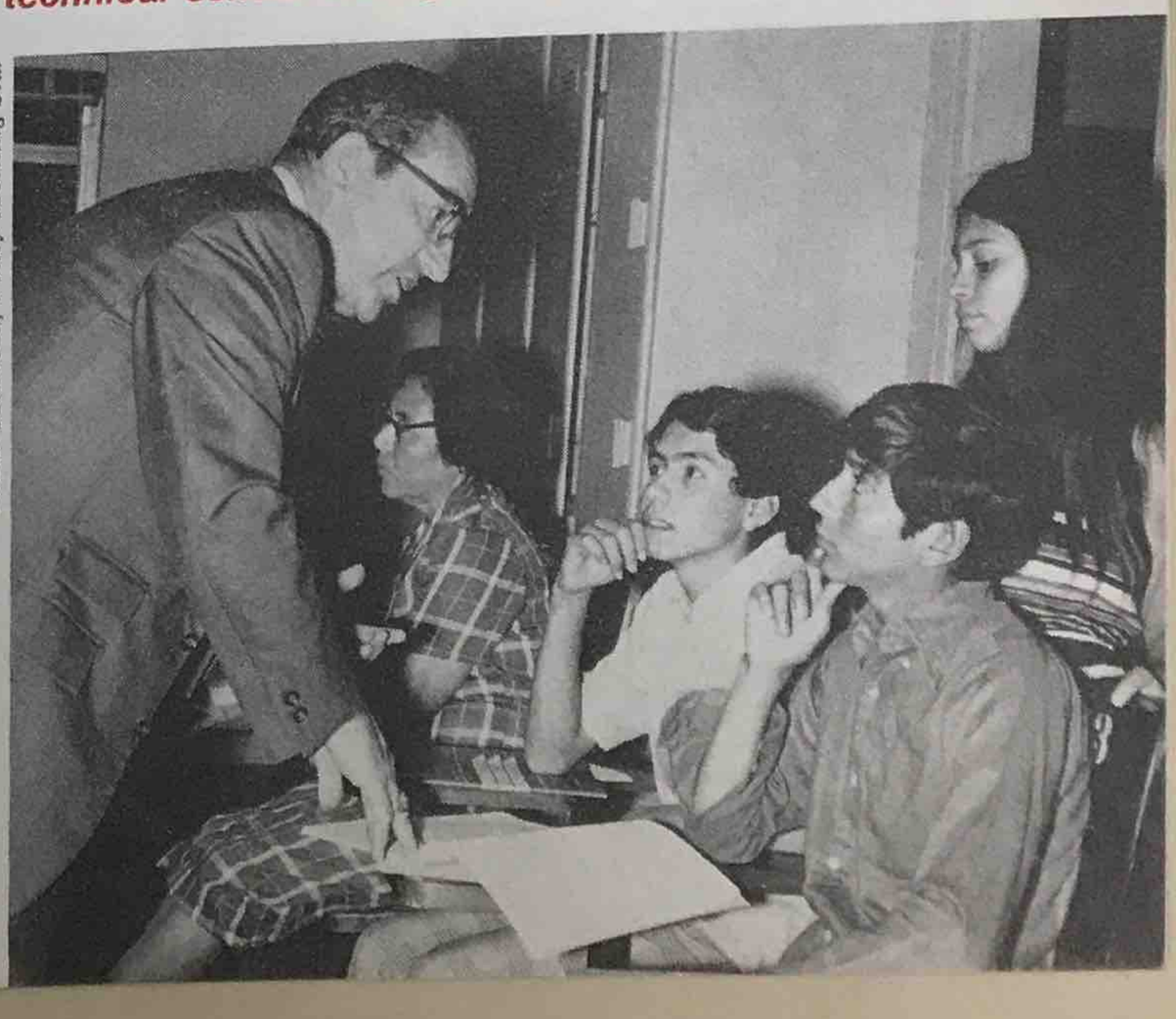
"No matter what we try, a large segment of the Mexican American community will not take the steps to protect themselves against TB." A volunteer leader of official and nonofficial health agencies for many years calls for a new and more intensive effort by Christmas Seal associations, political groups, and educational organizations.



Julian Mendoza, *Valley Morning Star*

Family ties are strong in Mexican American families. The old are loved and respected.

Education is a way up for the young. Here, a Texas technical school manager advises students.



Julian Mendoza, *Valley Morning Star*

We now have Mexican Americans employed at all levels in the public health services.

Yet, no matter what we try, there still is a very large segment of our Mexican American community that will not take the steps necessary to protect themselves against tuberculosis.

I suspect that it's going to take more than the efforts of our association to make real progress in this area. It's going to take the efforts of other groups, such as those concerned with the improvement of housing conditions, because crowded housing is a contributory factor. It's going to take the efforts of political groups and of educational organizations.

But I feel very strongly that the Christmas Seal association must concentrate its efforts in the field of health education and in the field of continuing pressure on the public health authorities to provide the money and the means to find tuberculosis, to cure it, and especially to educate the potential victims of tuberculosis as to how to protect themselves against it.

Some came because they were starving

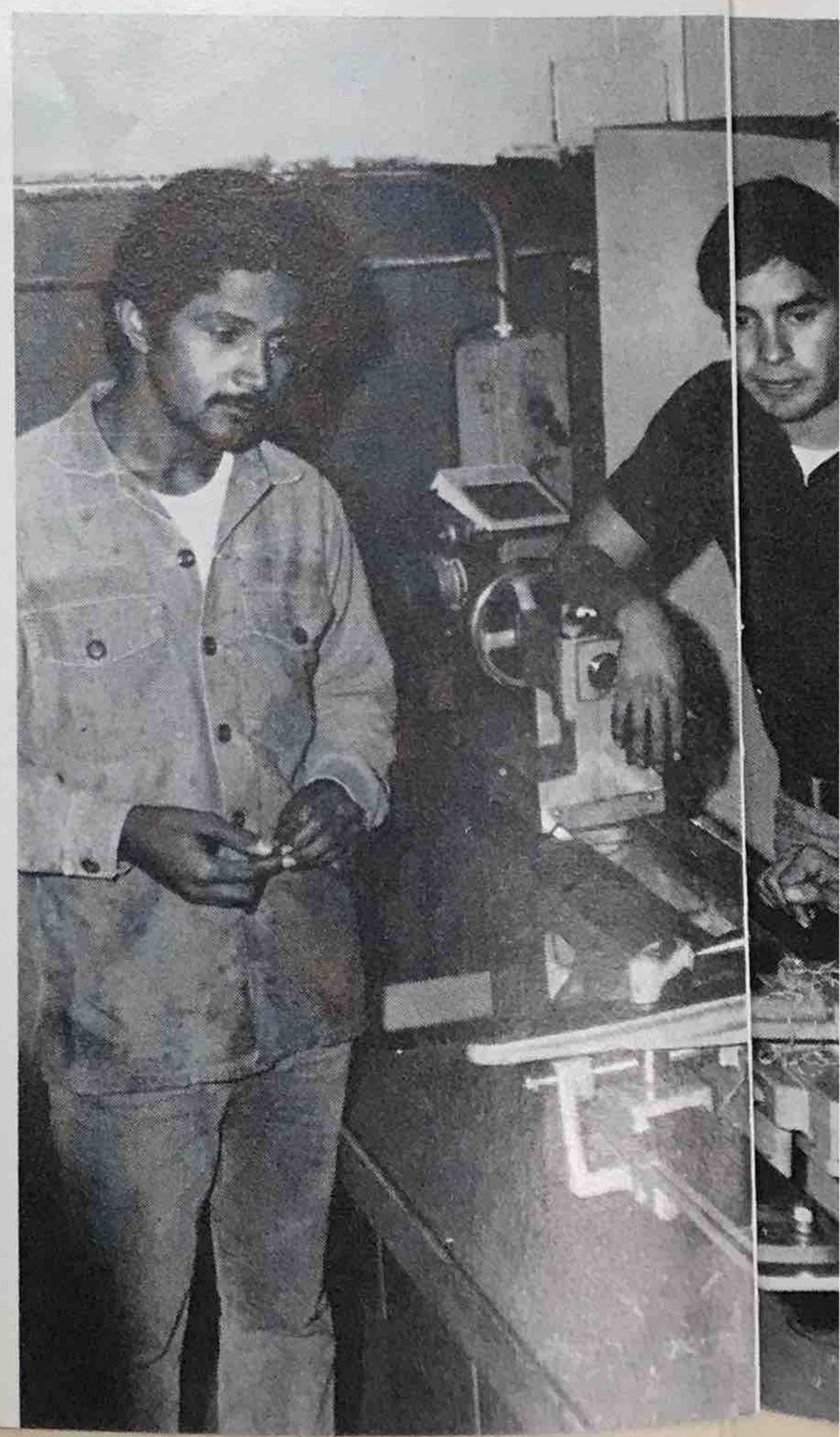
San Antonio is only 150 miles from the border. The fathers and grandfathers of many San Antonians came across that border from Mexico as refugees from the poverty that existed in Mexico at that time and that still persists in many parts. They came here to try to get a better grip on life because they were starving, literally starving, in the rural areas of Mexico and in some of the urban areas. Many of those people who came did very well here, their children went to school, they mastered the foreign language—English.

Many others did not do as well. And it is from their socio-economic-ethnic-educational problem that the continuing health problem of tuberculosis arises.

I certainly can't speak about the problems of other minority groups. But when it comes to tuberculosis and other lung-related disease problems of the Mexican American community in Texas and, I suppose in the entire Southwest, you're dealing with a problem that is more than a health problem. The tuberculosis problem centers precisely in that segment (and, unfortunately, it's the biggest segment) of the Mexican American citizens of our state who are in the lower income group—and who therefore face all the problems that any group faces in a poverty and barrio or ghetto environment.

Just in the past few years have sizable numbers of Mexican Americans begun to take part in social action groups.

Authenticated News International



In short, we haven't begun

I strongly believe that we have not come to grips with even the health aspects of this problem in the programs of the Alamo Area TB-RD Association, the Texas association, and the national association, and, for that matter, in official agencies.

Some programs are being clung to out of an idea that, if it worked in the past, it should work today.

We too seldom concentrate on building strong programs among those groups that suffer most from disease. And, when we try to build such programs, we too often fail to get at the root causes.

We must really get down to business and concentrate on the mission of health education. The doctors are doing their job; they provide the chemotherapy, but they are often handicapped by lack of understanding of their patients. Our staff people are doing *their* job—but, again, under the same handicap.

I feel most strongly that our boards of directors are not completely doing their job because we are not fully addressing ourselves to determining the most effective programs at the national level, at the state level, and especially at the local level. I say "especially locally" because it is the local board members who should best know what needs to be done in their home area.

In our home area, the Alamo area association must improve its service to the community by finding better ways and means of reaching the hearts and minds of the people in the barrios, the ones who carry the heaviest burden of tuberculosis.

People with TB stay away

We have tried many methods in San Antonio. We have gone into the barrios. We have employed and continue to employ Mexican American staff. Even so, the net result of practically every effort that we have made has been that the people who have the disease stay away.

They won't get their TB symptoms checked until it's a crisis situation. They won't come to the meetings. They will not respond to this or that appeal in their own language.

Perhaps the whole idea of approaching tuberculosis as an isolated disease is wrong. Perhaps we ought to work with comprehensive health clinics and similar facilities, carrying out our programs of education and case finding there, working with the health authorities, working with all other organizations. The articles from San Diego and Union City, California, in this issue of the *Bulletin* point in that direction.

If we get to the people when other groups are working on other diseases and trying to solve other problems, in a unified effort, then perhaps we can help those people who do have the disease tuberculosis.

Whatever our methods may be, I think it's up to the individual board member to be the catalyst that inspires the staff people and through them to assist the medical people so that this old disease, tuberculosis, which we have the means to conquer, can really be conquered.

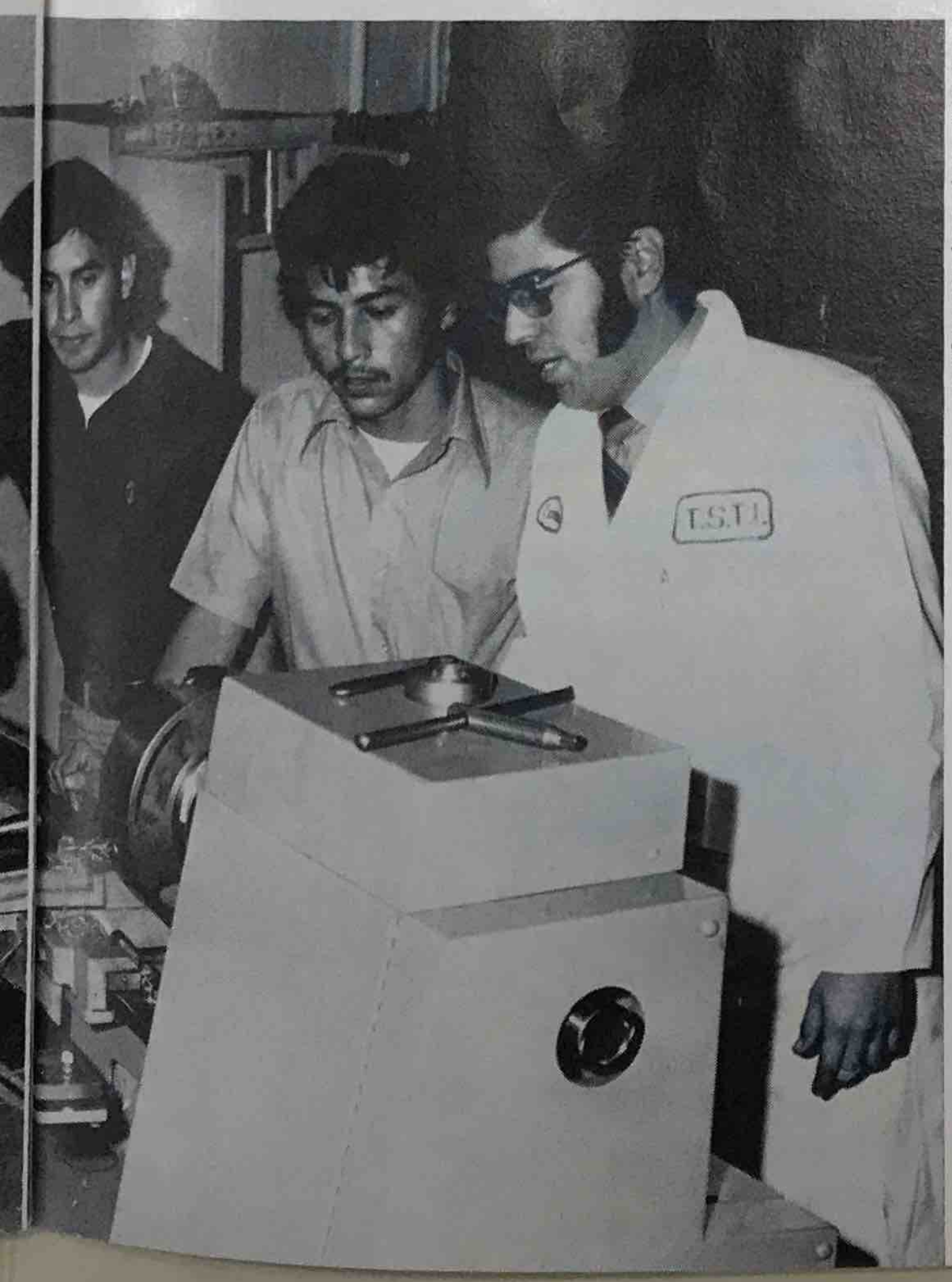
It's not the disease

Our problem is not the disease, it's the people. We have been addressing ourselves so much to the technique of dealing with the disease that we have overlooked a fundamental fact. The TB victim is not a "case." The TB victim is a man or a woman. We must reach this person's heart and mind, not with our own techniques but with the kind of message, approach, and motivation that he or she will respond to.

We must learn to talk with the TB victim in *his* language about the things that concern *him*. We must learn to look through *his* eyes. «

HENRY GUERRA is a board member of the Alamo Area TB-RD Association, the Texas TB-RD Association, and the national association. He has served as president of the local and state associations, and as a member of the Governor's Committee on Eradication of Tuberculosis in Texas, and currently is a member of the TB Advisory Committee of the Texas State Board of Health.

Mexican American students learn—in Spanish—how to operate a metal lathe.



Julian Mendoza, *Valley Morning Star*

Progress for a small community—

A HEALTH CENTER FOR ALL

Gabriel Arce

RESTING BETWEEN SAN DIEGO'S SOUTHERN SUBURBS and the international border with the Republic of Mexico is a community of 9,000 people. They are mostly of Mexican descent, and they share many common problems and dreams.

Among their problems is the highest unemployment rate in San Diego County. Those who are able to find work in San Ysidro are generally employed in farming, in governmental service agencies, and in the commercial activities serving the community.

One of the dreams of the people of San Ysidro has recently come true—the establishment of their own health center. Other advances which seemed far off just a few years ago in San Ysidro are now being built or on the drawing board, including smokeless and noiseless shoe and clothing fabrication plants, automobile and rifle assembly factories, and a new shopping center.

Things are changing quickly in this community, which occupies the extreme southwestern corner of the continental United States. From the mountains in the east, to where the Tijuana River meanders through tidal salt marshes down into the Pacific on the west, the tomato fields and horse corrals of San Ysidro are yielding to new buildings and progress.

Then—one physician. Now—a health center

San Ysidro had only one physician and no hospital when its health center opened in 1969. Today, over 6,000 San Ysidro Health Center members receive outpatient health services from a bilingual 65-person staff. Patients requiring hospitalization are transported to the University of California Hospital in San Diego, 15 miles to the north. The university administers the Office of Economic Opportunity grant which now backs the center, but soon the all-consumer board of directors will assume full responsibility for its operation.

Plans for the future include broadening the board membership to include professional providers and establishing prepaid medical insurance for members of the health center in order to develop it into a complete health maintenance organization.

Among the specialized clinical services available to the center's consumers are: pediatrics, obstetrics and gynecology, optometrics, dermatology, podiatry, dental services, and individual and family guidance counseling. A fully equipped laboratory and pharmacy are also provided. Patient follow-up is carried on by outreach workers of the health center staff. Social workers help with housing, education, job training and placement, and economic assistance.

Children of member families receive immunization against diseases like whooping cough, measles, diphtheria, tetanus, and smallpox as part of the services of the well baby program, which is the most popular of all the services. Dental and optometrc services are the next most heavily used. Vaccines for the well baby program are provided by the California Department of Public Health and San Diego County.

Gabriel Arce, clinic administrator, shows the location of the health center on San Ysidro map.

A clinic family participates in the opening of the new San Ysidro health center in June 1972.

The San Ysidro Health Center near San Diego is a dream come true for the Mexican American people there. Backed by government funds, the bilingual staff offers clinical care for a wide range of health problems—including tuberculosis.

The Lung Association of San Diego and Imperial Counties is currently funding a respiratory health program for clinic members. PPD-S skin testing done to date indicates a rate of approximately 30 percent positive reactors among those tested. So far, one active case of TB has been identified and hospitalized through this program.

A modern X-ray facility, to be operated by a radiologist and a technician, is planned for the future.

Residents work there

The San Ysidro Health Center is operated largely by community residents who have been trained for the job. Many of them—from administrators to secretaries—have continued their education so that they can better serve the membership of the health center. Most of the center staff who deal with patients must speak both Spanish and English fluently, since 60 percent of the membership speaks only Spanish. All official documents are drafted in both languages.

Cultural medical patterns of many of the patients have to be considered by those operating the center's programs. Husbands and fathers, for instance, will rarely seek treatment unless they are so ill that they are unable to work. Children are the family members most likely to be seen for medical attention, with housewives the next most seen group. The men, it seems, will often not admit to their own illnesses but will sacrifice anything to see their women and children get to a doctor when they are sick.

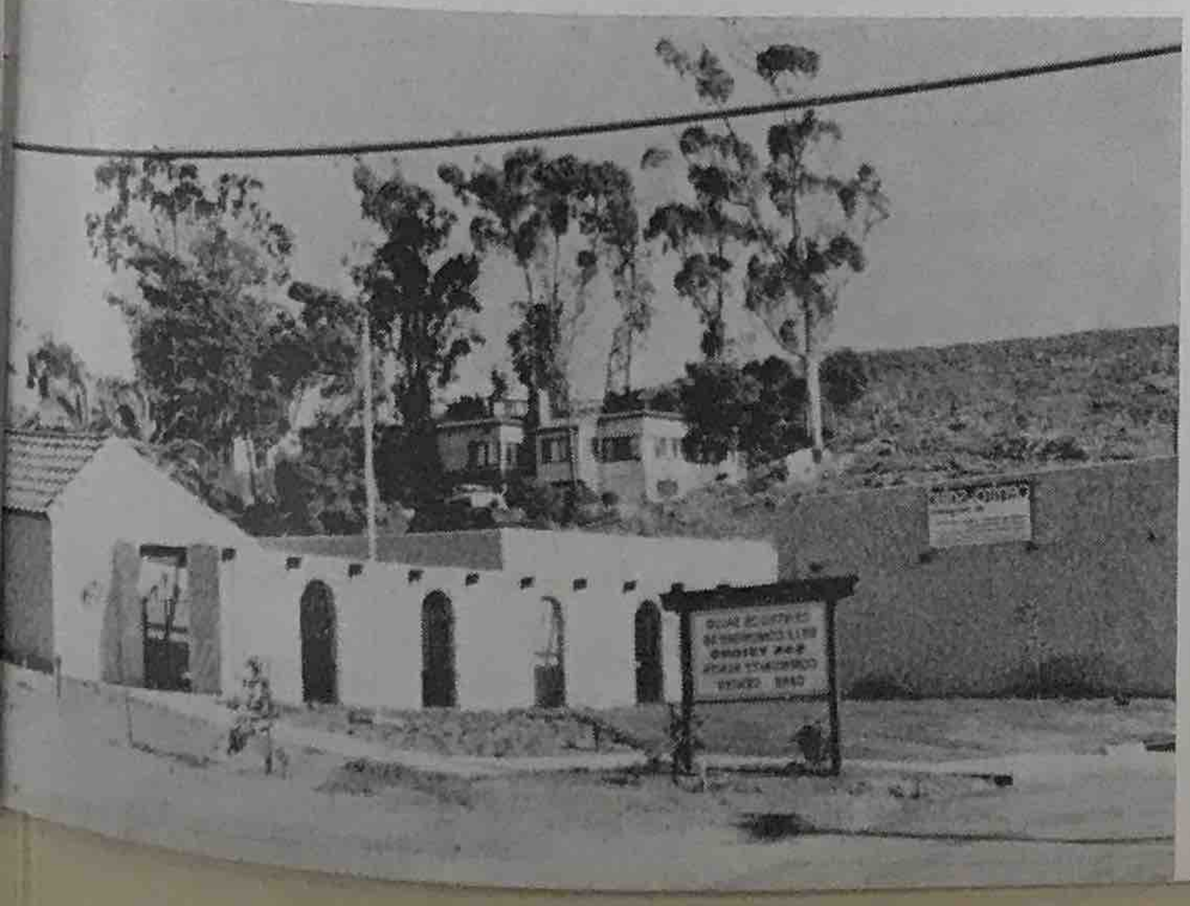
Many of the people in San Ysidro complain that doctors in the U.S. are not as humane as those they were used to in Mexico. Mexican doctors, recognizing the psychosocial factors in illness, generally spend much time simply talking with their patients. American physicians, regardless of ancestry, are more physical symptom oriented, and those practicing at the San Ysidro Health Center work to develop a milder, more empathetic approach toward each of the 2,000 patient members they see every month.

Something to be proud of

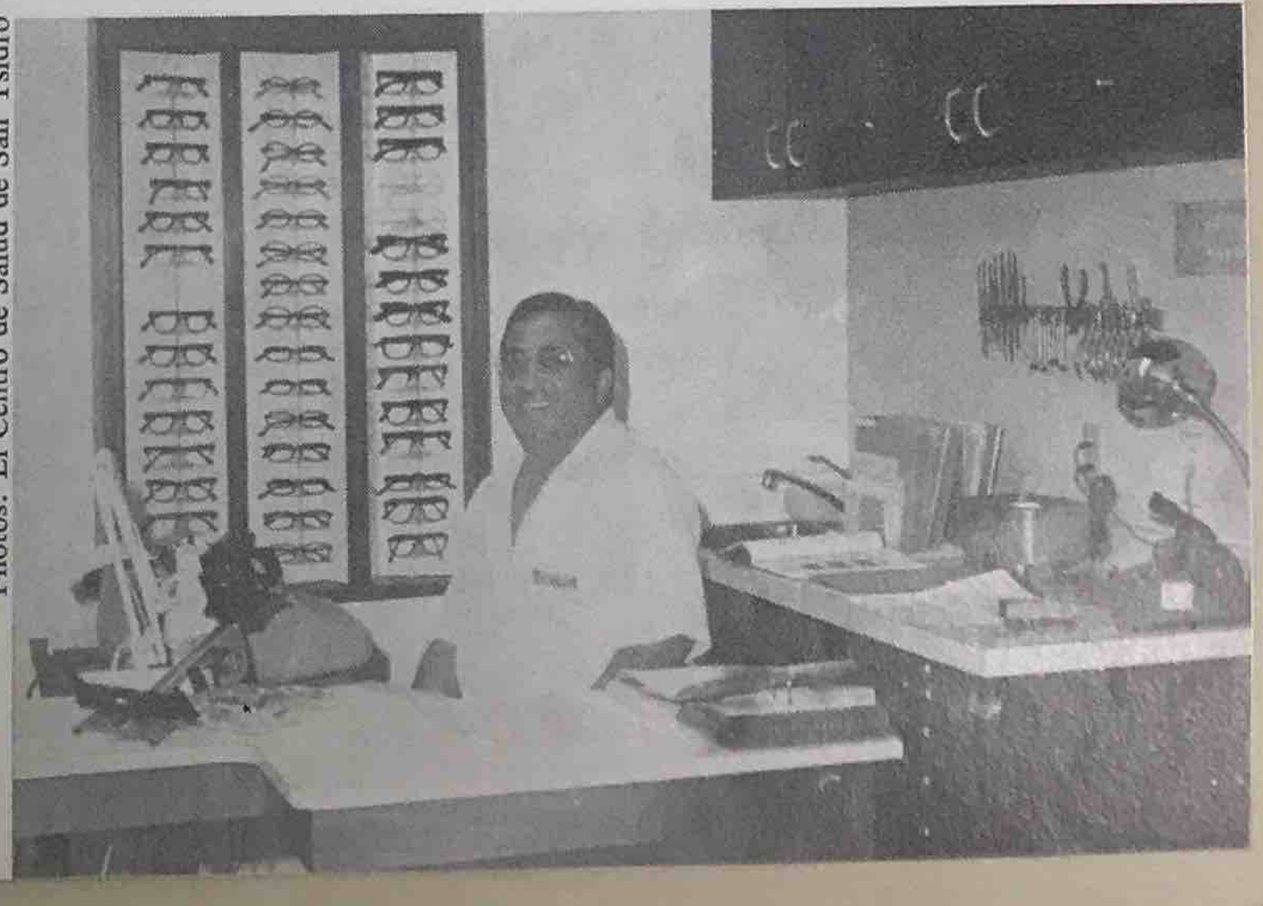
El Centro de Salud de San Ysidro—The San Ysidro Health Center—is providing health services where there were practically none before. It is a source of pride that this small, rapidly urbanizing community has carried its *Centro de Salud* from the first seed of an idea to the beautiful and busy health care plant it now is. The political struggles have been many, but there has been constant citizen support for the establishment of the health center. From the hill of the *Centro,* Tijuana can be seen just to the south, and the new skyline of San Diego to the north. *El Centro de Salud* is a vital link in the bridge between them. *Viva San Ysidro!* «

GABRIEL ARCE is administrator of the San Ysidro Health Center, near San Diego, Calif. He is also a board member of the Lung Association of San Diego and Imperial Counties. Mr. Arce was born in Tijuana, Baja California, Mexico, and holds a Bachelor of Law degree. Before joining *El Centro de Salud de San Ysidro,* he was director of the Berlitz School of Languages in Mexico City and San Diego, Calif.

The new center (below) is a far cry from the small house where the clinic began in 1969.



Optometric assistant Eduardo Merino is prepared to fit clinic members with correct lenses.

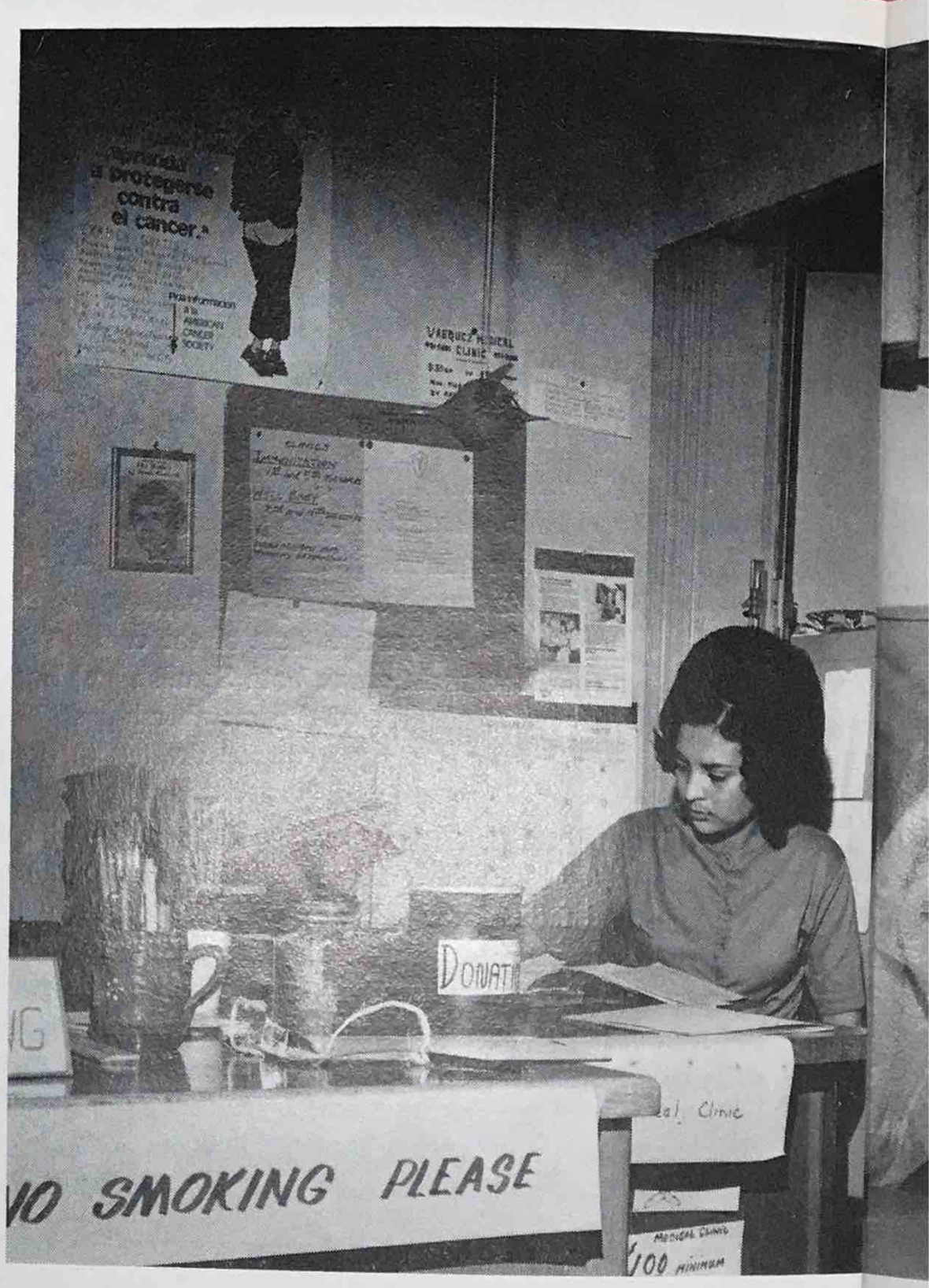


Photos: El Centro de Salud de San Ysidro

A HEALTH CENTER BY AND

Ben Torres

This health clinic is a bootstrap operation which serves the Mexican American community near Oakland, California. Its financing started with no public funds. It got going with a spaghetti dinner and $50 worth of medicine on credit.



Clinic appointments are made at this desk. Those who can pay are asked to donate $1 for a visit and $1 for a prescription.

La Clinica Medica Tiburcio Vasquez in Union City, California, has been an endless struggle for funds. But the corner has been turned now. A year ago, funds were sought to keep the clinic open a couple of hours a week. Today, funds are sought for expansion. For new programs. For larger facilities.

Even so, the battle isn't even half-won. We realize this as we look back on the stormy past couple of years. In February, 1971, Nell Randall, a family planning director, was working with Dr. Stephan Miller at the Union City Family Planning Clinic. Both knew that family planning was not the complete answer for the health problems besetting the little Mexican American town, which was rapidly becoming an inner-city barrio surrounded by large middle-class housing tracts.

Over 60 percent of the city's families earn less than the Alameda County median income of $10,000—and of this 60 percent, 90 percent are Mexican American. The doctor's ratio is 7,500 to one. Over 6 percent of Union City's population, mostly field or factory workers, is medically indigent. The nearest county hospital is ten miles away, and public transportation is all but nonexistent.

Mrs. Randall and Dr. Miller were not alone in their concern. The Union City Health Committee was also thinking along medical clinic lines.

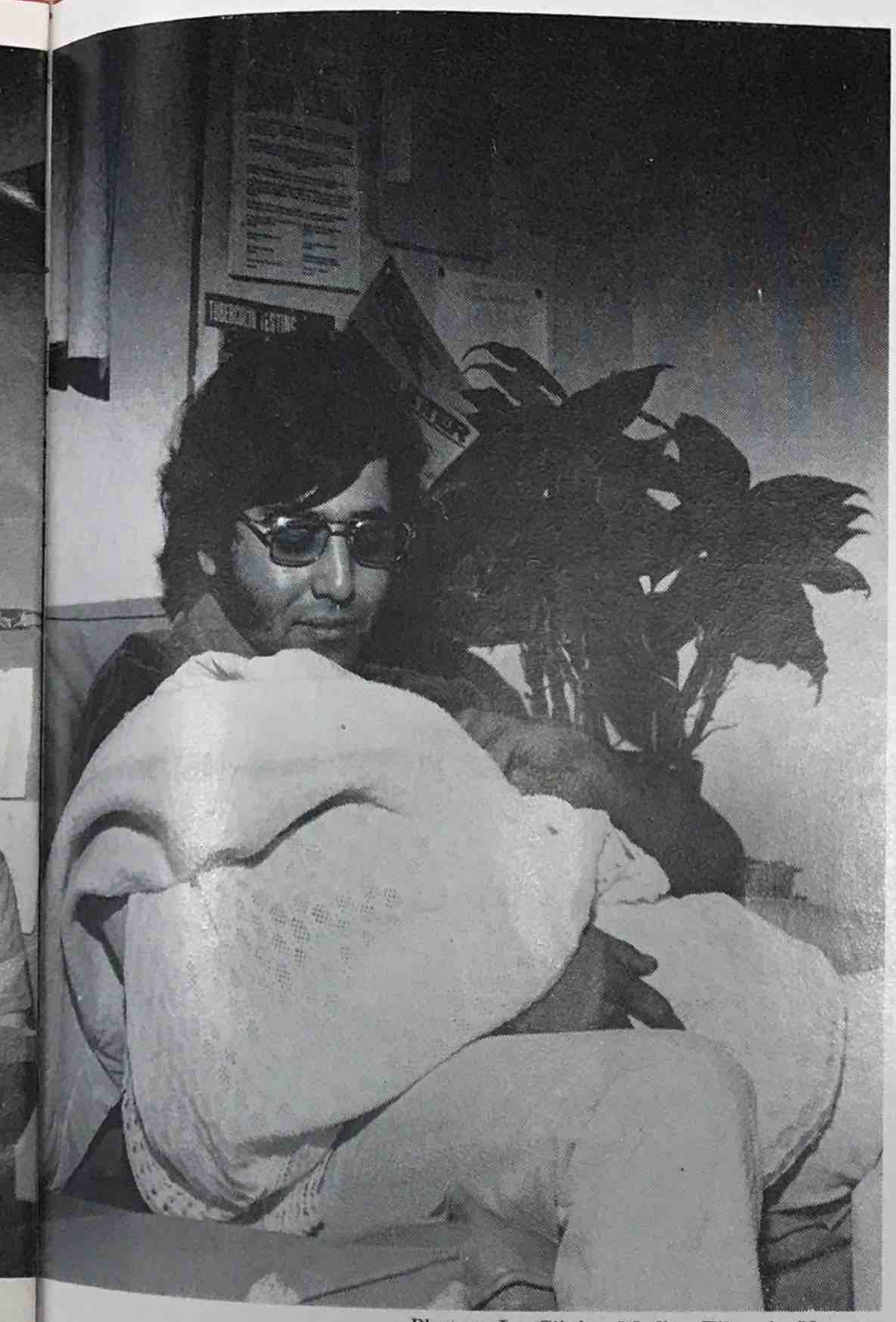
First clinic—two hours a week

The health committee and the family planning clinic got something going with $50 worth of medicine on credit. A clinic opened for two hours a week at the Family Planning Center. The first small financial shot in the arm came when two activist groups, the Brown Berets and Venture House (a drug crisis group), sponsored a spaghetti dinner and raised $350.

Because I was already involved in community work and was a board member of the Puerto Rican Union for Mutual Aid, I was asked by the Union City Health Committee to help tap state, local hospital, and foundation grant funds. At a later date, I was hired as the clinic administrator. Funding is still one of my prime concerns.

The clinic grew steadily. It now covers primary pre-

FOR THE PEOPLE



Photos: La Clinica Medica Tiburcio Vasquez

A father waits for his appointment. Some Mexican Americans continue the old custom of keeping the baby's head covered.

ventive and diagnostic care as well as family planning work. The clinic also has two VD clinics, a well baby clinic, and a program to provide glasses for needy school children; and it does cancer, kidney, and TB screening. The last, conducted with a two-year grant from the TB and Health Association of Alameda County, provides a comprehensive tuberculosis control program from detection through chemoprophylaxis.

Not all easy going

There have been many setbacks. The burning of the module given by Kaiser Industries was one. We owned that much-needed building just 12 hours.

Who did it and why? There is no local opposition to the clinic. The arson, I think, was an accident. A case of mistaken identity. I don't think whoever did it knew the building was to be used for the clinic.

The community does resent the fact that local school children are forced to use modules and bungalows instead of good school buildings. There's resentment toward industry arriving with their own workers when local unemployment is high. The module was sitting temporarily on industry-owned property.

The clinic honors Tiburcio Vasquez. Who is he? In history, there were three men by that name. La Clinica is named for the last one.

This Vasquez was a Robin Hood of sorts. He was also a dapper, highly educated ladies' man and a native Californian who resented the intrusion and exploitation by the gringos into the California territory. He was executed and is buried in Santa Clara Cemetery. Around here he is thought of as a revolutionist, not a bandit.

Today, the clinic that bears his name is open to all low-income families in the community three hours a day, five days a week. Those who are able to pay contribute $1 a visit and $1 per prescription. From March 1, 1971, to December 31, 1971, the clinic saw 1,326 patients. That figure has now more than tripled. So far as TB is concerned, we screened 188 persons for TB in the twelve months of 1972. Sixteen of the 188 were found to be positive reactors, and eight of these were placed on isoniazid. However, all 16 are being followed by a physician, and those not receiving preventive treatment receive six-month X-rays and are being checked very carefully.

On my desk right now are blueprints for a $1,300,000 medical facility. The clinic will be closer to the center of town. Excuse me while I sharpen my pencil and go back to my stack of "Where the Money's At" guides. «

BEN TORRES is administrator of the Tiburcio Vasquez Medical Clinic in Union City, Calif. Before joining *La Clinica Medica Tiburcio Vasquez,* Mr. Torres was heavily involved in community work and served as a board member of the Puerto Rican Union for Mutual Aid. He is a cardiac retiree from Navy engineering and was formerly a **Honolulu policeman.**

AMERICAN LUNG ASSN. MEMBERSHIP MEETING
Pursuant to Article IX, Section A, paragraph 3 of the Bylaws of the American Lung Association, formerly the National Tuberculosis and Respiratory Disease Association, notice is hereby given that the annual meeting of the membership of the Association will be held on Wednesday, May 23, 1973, at 4:00 p.m. at the Statler Hilton Hotel in New York City.

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This concludes the first half of a two-part series on the health problems of Mexican Americans. Part 2, to be published in the May NTRDA Bulletin, will feature three additional articles on this topic.

Lucy Guzman, young staff member of the San Jacinto TB-RD Association (Houston, Texas), will discuss some of the problems and satisfactions of her work and will emphasize the strengths of the Mexican American culture. Vera Saucedo, board member of the Los Angeles association, will comment on some of the political realities in her city, which has the largest concentration of Mexican Americans in the U.S. Carlos Tejeda, M.D., staff member of the Chicago Lung Association, will report what happens to the Mexican American when he emigrates to the north.

Southwest Council of La Raza