

Research paper

From Puebla to East Harlem: healthcare for a rapidly emerging community

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What is known on this subject

- Traditional beliefs, including the concepts of balancing the four humours, hot and cold, supernatural powers, and folk healers, play an important role in Mexican healthcare.
- The concept and value of preventive medicine, including anticipatory/routine healthcare visits and screening tests, are virtually unknown in Mexico.
- By comparison with the increasing prevalence and severity of chronic conditions such as obesity and diabetes, asthma in Mexico is generally mild.

What this paper adds

- This paper documents strategies that have been undertaken in order to achieve a critical mass level of cultural awareness, knowledge and competence of a new and unfamiliar emerging community (i.e. Mexican) in New York City.
- The story of the building of La Clinica del Barrio, a clinic in East Harlem, New York, represents a medical centre's response to a rapid influx of Mexican immigration beginning in the late 1990s. It demonstrates an application of a physician-led private practice paradigm within a municipal safety-net healthcare system, and how this centre served the Mexican community.
- This paper demonstrates the importance of active community partnerships. The New York Mexican Consulate became the major outreach and referral arm for La Clinica del Barrio.

ABSTRACT

In the winter of 1998, the first of many Mexican families arrived at one of New York City's Health and Hospitals Corporation clinics in East Harlem. This paper traces the author's 10-year experience of addressing and serving this unique community as director of this clinic. Finding a most willing ally in the New York City Mexican Consulate, which arranged visits to Mexican healthcare centres in California, Chicago and Mexico, he acquired the cultural competencies that allowed him to make appropriate adjustments to his clinic's practice. At Oakland's *La Clinica de La Raza* ('the Clinic of the Race' – that is, Mexican race), family structure and machismo were elucidated. In Chicago, the mental effects of emigration were depicted. However, it was not until the author visited Mexico that the full picture emerged. Socio-cultural values with regard to the experience and expression of illness, including gender roles and stoicism, were demonstrated. Systems and structures of healthcare networks, as well as patient expectations, were identified.

Conditions that included obesity, diabetes, asthma and mental illness were explored at Mexico's referral centre, the National Institute of Health.

First-hand knowledge was brought back and incorporated into the expanding family health centre. As Mexicans came to represent nearly one-third of its patient population, the centre was re-dedicated and renamed *La Clinica del Barrio* (the clinic of the neighbourhood). It is now recognised by the State of New York Legislature as providing community-responsive healthcare for the people of East Harlem.

The paper outlines one particular approach to the achievement of culturally competent healthcare, and closes by linking this development to the broader aims of the Office of Minority Health.

Keywords: cultural competence, Mexican healthcare in New York City, Mexican immigration and East Harlem, New York

Give me your tired, your poor,
 Your huddled masses yearning to breathe free,
 The wretched refuse of your teeming shore.
 Send these, the homeless, tempest-tossed to me:
 I lift my lamp beside the golden door

Emma Lazarus (1883)

Introduction

Across the globe, political, economic, persecutory and other pressures trigger immigration movements, but what happens when these immigrants, especially those who lack resources, reach their destinations? Who cares for them if they are sick? And do their medical providers understand their needs and norms? In this paper, the 10-year experience of one physician, who moved from a predominantly white and wealthy private practice into the world of a publicly funded family health centre in East Harlem, New York, is used to demonstrate the kinds of activities that can be useful when serving a new immigrant group. The paper examines how the application of a physician-led private practice paradigm within an existing bureaucratic health-care model allowed the medical facility to grow and respond more effectively to the needs of newly arriving Mexican immigrants. A review of the literature indicates that although it is rich with discussions related to cultural compatibility and competence, there is little coverage of actual experience in trying to put these theories into practice. This article adds to our understanding of cultural competence, by looking at how one provider responded when his facility was faced with a new wave of immigration.

East Harlem, New York and its immigrant history

Sandwiched between the East River to Fifth Avenue and from 96th Street to 141st Street, East Harlem, New York has been a vibrant and ever-changing terrain. By comparison with New York City, age-adjusted death rates, infant mortality and the prevalence of chronic diseases are exceptionally high (New York City Department of Health and Mental Hygiene, 2006). A group of local students accurately captured the flavour of the many faces of this 2.2-square-mile plot of land, from colourful romantic songs filled with pride, to draining poverty, drugs and violence:

Sounds and smells of East Harlem

Fried chicken, macaroni, platanos, rice and beans,
 Urine on alleys, liquor, cigarettes, trees, weed,

Young mothers and fathers fighting before the eyes
 Of the future,
 Banging music all the time.
 Guitars, maracas,
 Skidding cars, honking horns, people calling, laughing,
 Babies crying, gunshots, firecrackers, police sirens,
 Hotdogs from vendors in the street,
 Sounds of morning music,
 Cashews and roasted peanuts, freshly peeled oranges
 and mangos.

Students at the Frederick Douglas Academy II (2003).
 Courtesy of Community Works' Public Art Exhibition/
 Workshop program 'Latin Roots: East Harlem'

From the late 1800s, responding to a large supply of cheap housing, East Harlem experienced a large Italian as well as eastern European, African American and West Indian influx. Puerto Ricans arrived after the First World War, establishing the first enclave of Latinos in what was by that time known as *Italian Harlem*. After the Second World War, with increased migration of this group as well as new Latinos from the Dominican Republic, Central and South America, this now overcrowded area became referred to as *Spanish Harlem* or *El Barrio* (meaning 'the neighbourhood'). With 142 000 people per square mile in 1950, it represented one of the highest-density regions in the world. In addition to the settling of numerous other groups, including Africans from the Caribbean and West Africa, Turkish and Chinese, the pattern of successive Latino immigration continued, and to this day East Harlem is the largest predominantly Latino community in New York City (East-Harlem.com, 1999).

Although Latinos have been dominant for many years in East Harlem, immigrants from Mexico were rare, as few Mexican immigrants settled in the north-east USA. The American Southwest, including California, New Mexico, Arizona, Texas and parts of Utah, Colorado and Nevada, were part of Mexico prior to the Mexican–American War in 1848. The Treaty of Guadalupe Hidalgo permitted Mexicans to move freely between the USA and Mexico until the creation in 1924 of the Border Patrol, which considered Mexicans to be illegal aliens. This change of policy heralded a dramatic rise in anti-Mexican immigration sentiment, and initiatives which led to discrimination, violence and mass deportations (Centre for Latin American Studies Migrations, 2003). However, Mexicans continued to enter the USA, like most newcomers, in order to find a better life. They represented the largest immigrant group, and their numbers grew from under 800 000 in 1970 to over 25 million by 2003. By 2005, the total US immigrant population was estimated to be over 37 million, of which 11 million (nearly 4%) were from Mexico. It is estimated that this number will continue to rise at a rate of 3.5–5 million per decade until 2030 (US Census Bureau, 2005).

It was only as the 20th century was drawing to a close that New York City first began to experience Mexican immigration, and East Harlem was a major destination. New York City is no stranger to demographic diversity and shifts. The New York City Health and Hospitals Corporation (HHC), the largest municipal healthcare system in the USA, cares for the city's poor and underserved, including immigrants, and over 130 different languages and dialects are spoken in its network. By the mid-1990s, nearly 40% of the city's population were foreign born, a figure which rivalled its peak of immigration in 1910. Furthermore, for the first time, Hispanics replaced blacks as the second largest racial/ethnic group (Moss *et al*, 1997).

My arrival in East Harlem

I arrived in this neighbourhood in 1995, and the territory was totally unfamiliar to me. Although I completed my medical training in a busy inner-city hospital, I retreated back into the pristine and familiar hills of suburban New Jersey, where I had been born and raised. My patients' culture was close to my own, so there was little need to consider cultural differences. Yet after a dozen years as managing partner of a successful private practice, I felt unfulfilled. I realised that materialism had replaced the values that once energised me and made me want to become a doctor in the first place. So when an opportunity arose in a public hospital in East Harlem, I grabbed it.

My passion for my trade was refuelled as I became the medical and operations director of four community health centres which were part of HHC. One of these clinics was the '120th Street Family Health Centre' – a start-up site in the heart of the *Barrio*, which, as the main hospital's medical director confided, 'hadn't gotten off the ground.' I was confident that the steps I had taken in my private practice would succeed anywhere, and I took the practice as designed by HHC and added some touches that I had picked up over my years in New Jersey. However, I soon realised that the *Barrio* was not New Jersey, and that there were considerable and significant cultural differences. The stethoscope that I used in the suburbs worked quite well in Spanish Harlem, but the French that I learned in high school did not, so with a lot of encouragement from my patients and a tutor, I acquired a basic fluency in Spanish. I connected to the neighbourhood institutions and reconfigured the clinic from the ground up, emphasising, from my New Jersey lessons, outreach, personalised care and physician ownership, a role involving leadership and accountability, unusual in public facilities whose tables of organisations were bogged down with numerous lines of reporting. In

many ways, I did not know what I did not know, and I did not think to look at what others had written or accomplished in serving communities like the one in which I was now based. Despite this, by 1998 the clinic was a popular and respected resource for East Harlem, caring for many racial and ethnic communities. Running primary and select subspecialty care services six days and four evenings per week, it distinguished itself as one of the most profitable of the 80 community health centres in the city's municipal healthcare system.

Like most service industries, having neither predictable nor final pictures, medical practices must be cultivated, continuously marketed, and driven by ongoing community needs assessments. This critical process begins with hunches, and leads to assessments, recommendations, and finally actions (changes). These cycles shape and reshape the organisation and often its mission. I had learned well in the competitive world of private practice. Instead of being satisfied, complacent and resting on my laurels, I kept a vigilant eye, scanning for new issues, communities and needs.

The emergence of a new community

It was a cold, wintry afternoon in 1998 when a shivering Mom, with her sick infant wrapped in a *serape* (scarf), came to the clinic in East Harlem. Somehow she was different from my other patients. Before long, other patients like her followed. So it was, as I welcomed that woman and her baby, that the hunch of a rapidly emerging community in New York City, with its specific and distinctive healthcare issues, was sensed. As Mexican families increasingly found their way to 120th Street, we, as well as New York City as a whole, were caught off guard, unfamiliar with and unprepared to address and serve their needs.

Who are these people?

Although my experience in both the privileged suburbs and the poor inner city had shown me that all communities respond well to caring medical providers in friendly, well-organised, efficient and aesthetically pleasing facilities, this simple formula only works if you know where your clientele comes from and what they expect. The problem is to determine how the system could begin to link with a community that is so foreign in so many ways. Familiarity with Mexican heritage, culture, social and healthcare issues was essential. To equate this new group with our more familiar Puerto Rican and Dominican populations, as many of us initially did, was as wrong and risky as considering

all Spanish speakers to be uniform. Scrambling, I asked our arrivals a host of questions, but at that time they were hesitant about saying much more than 'Mexico.' The internet was not a resource with which I was yet well acquainted. A trip to the library yielded nothing but colourful photos and topographical maps. Desperate for answers, I opened a phone book, and in my broken Spanish introduced myself. From that moment on, the Mexican Consulate and its staff became our teachers, allies and dear friends.

Like many consulates, that establishment represented a safe-haven and anchor for people living so far from their homeland. I was invited to their office, where the *Consul Generale* (head of consulate) told me that virtually all of the newcomers to New York City, and East Harlem, were poor, uneducated, undocumented, and from a rural region of Puebla, an industrial state some 80 miles southeast of Mexico City. Within a year or so, they also began arriving from other rural areas surrounding Mexico City, including Guerrero, Jalisco and Michoacan, as well as from Mexico City itself.

The stage for this dramatic migration, he said, was set in the middle of the decade. In his article entitled *Nafta Should Have Stopped Illegal Immigration, Right?*, Louis Uchitelle (2007) describes the cascade of events that helped to increase the flow of (illegal) immigrants from Mexico. The North American Free Trade Agreement (NAFTA), which was rolled out in 1994, was sold on a package of improving a failing Mexican economy and decreasing immigration, but did neither (Uchitelle, 2007). Nearly 30 000 Mexican businesses were in fact eliminated, as manufacturers lost tariff protection, and less expensive labour (most notably Chinese) and merchandise became available. The peso crisis of 1994–1995, and the subsequent steep recession, added to the predicament, causing Mexican workers to fall further behind, and many to look northward (Bybee and Winter, 2006).

I asked why the people came to New York City and East Harlem. The Consul General, and later my patients, explained that it was generally because of information passed on by word of mouth. This network effect was described by Jeffrey Passel of the Pew Hispanic Institute as part of a wider context of flow of Mexicans to the USA which produced a momentum of its own (Uchitelle, 2007). Some arrived, I was told, with the intention of saving enough money to eventually return to Mexico, but most hoped to later bring their families to settle in this land of opportunity.

New York City was the portal of entry to a new country and a new life, yet the journey to get there was a tremendous challenge. Many people were smuggled across the border at a cost of thousands of dollars, and were subjected to unsafe and frightening conditions. Those who were not deported, or worse, on their way across the country, *Pueblanos* (also spelt *Poblanos*) – that is, people from the Puebla region – arrived in New

York City at best weary and with nothing. Others were further burdened by the debt and constant threat of paying off their *coyote* (an individual who smuggles people across the Mexican–US border for monetary gain; Gazzar, 2005). Yet, despite these hardships, and soon finding themselves exploited in low-earning labour sectors, working 12 hours a day, seven days a week, the income that they were receiving in New York City was better than they could ever have hoped for in Puebla (Rivera-Batiz, 2003).

Learning from others

The Consul General and his staff suggested that my learning curve should be accelerated. Over the next two years, they arranged visits for me to meet with healthcare providers in California, Chicago and Mexico.

Medical practices serving Mexican-Americans

California, having hosted more Mexicans than any other region in the USA, has vast experience of delivering their healthcare. Despite laws like Proposition 187, passed in 1994, barring illegal immigrants from schools, health clinics and other public programmes, their numbers climbed to nearly 10 million by 2003 (US Census Bureau, 2008). I first visited Oakland's *La Clinica de La Raza* ('the clinic of the race', the race being Mexicans), a nationally recognised prototype for Mexican community-responsive primary and select subspecialty care. It was founded in 1971 by community activists and physicians, and has 22 sites which care for over 200 000 patients, mainly Mexicans, annually. Spending time with its providers, administrators and patients was illuminating. The Director of Obstetrics and Gynaecology at San Francisco General Hospital, the public hospital of that city, which also served a Mexican-dominant population and was affiliated with *La Clinica de La Raza*, explained that Mexican women, contrary to stereotyping beliefs, commonly practised birth control, often without their husband's knowledge. Initially impressed by the fact that Mexican fathers accompanied their families to our clinic (unusual in our experience), my guide taught me about *machismo* (male chauvinism), the sense of honour that is vital to a Mexican's sense of manhood, the publicly submissive role of the wife in relation to her husband, and the threat and under-reporting of mental and physical abuse.

Although most Americans continue to think of the Mexican population as being confined to the southwestern states, Chicago and the Midwest have witnessed Mexican immigration for well over half a century. The most dramatic increases occurred during the last three decades, as Chicago by 1960 emerged as the third largest Mexican city in the USA, with only Los Angeles

and San Antonio having larger Mexican populations. By 1970, the Mexican-origin population in Chicago exceeded that of every state except California and Texas (Hutchinson, 1999). The multi-ethnic and densely populated metropolis of Chicago, with its immense, vertical buildings and fast pace, closely resembles New York City. I met the Mexican Consul General there, and toured the *Alivio (Relief) Medical Centre*, a federally funded community facility that was founded in the mid-1980s to meet the needs of predominantly Mexican immigrants who were neglected by the existing health systems, and its public hospital, Cook County, also serving a predominantly Mexican population. I learned how rapid and disruptive migratory transitions from sparse villages in Mexico to the frenzied tempo of Chicago led to anxiety, depression and suicide, and began to grasp how such mental illness was being manifested in our transplanted families.

Lessons from Mexico

However, it was not until I visited Mexico that I began to join the dots. My tour there was based in the *Valle de Mexico*, also referred to as the Mexico City basin, which holds over 20% of Mexico's population. Mexico City, the third most populated city in the world, with nearly 23 million inhabitants, is the home of Mexico's National Institute of Health (NIH), which consists of ten (general and specialty) medical facilities that serve as the referral resource for the entire country (Brinkhoff, 2008). More than 80% of Mexicans are uninsured, and these public medical centres are available to them at a fee equivalent to 5 US\$ per visit, excluding pharmaceuticals. Although promoted by the government as nominal, this cost was considered prohibitive by the average Mexican. In terms of size and proximity, their hospitals and satellite clinics were similar to what I was used to in New York City. The *Dr Manuel Gea Hospital, General*, like Metropolitan Hospital Centre, my clinic's affiliated tertiary centre, had nearly 400 beds, and its satellite clinic, *Centro de Salud* (literally, 'centre for health', a facility that provides primary care medical services), about one mile away, reminded me of our clinic on 120th Street. However, after spending time at both, it became clear that functionally they were worlds apart from East Harlem.

Although the role of traditional beliefs and medicine, including the concepts of balancing humours, hot and cold, and supernatural powers, appeared to be less common over time, our guides explained that such changes have been slow to reach rural regions such as Puebla. Before attempting to access clinics or hospitals, various sources are generally exhausted over a period of months to years, including relatives, neighbours, and a combination of herbalists, massage therapists, midwives and *cuaranderos* (lay or folk healers who intervene in various physical and spiritual routes). Open pharmacy stands were common, literally located

on most corners near hospitals. Pharmacy stores, operated by proprietors without professional credentials, also played an active role, as medications were loosely regulated, and advice was freely given. Strolling into a pharmacy, I complained of asthma. Without any hesitation, or examination, the owner offered me a number of sophisticated prescription drugs at a fraction of their cost in the USA. He suggested that I should take them and return in a week if my condition remained unimproved.

The concept of preventive medicine and the value of healthy lifestyles, which is emphasised in the USA, is virtually non-existent in Mexico. This lack of proactive health promotion explains, to some degree, why conditions and diseases in that country are more commonly discovered and addressed at late stages. A radiologist at the NIH cancer centre noted, with frustration, that because mammography was only used as a diagnostic procedure, rather than for screening, women showed up after [too] long periods of time with large, painful breast tumours, usually with metastases and grave outcomes. Gender roles and sexuality also played a role in this disregard for prevention. A 60-year-old director of a private hospital would not hear of having a prostate examination, nor would he consider a colonoscopy. 'Real men don't do this', he declared.

My trip gave me insight into a number of specific medical conditions. As the new century began, East Harlem's health report card was abysmal. The incidence of AIDS, tuberculosis, hepatitis and gonorrhoea, to name just a few illnesses, was substantially higher there compared with New York City, a grim reminder that while most of the USA enjoyed improving medical care and outcomes, vulnerable populations languished (New York City Department of Health and Mental Hygiene, 2003). Obesity and diabetes exemplified such disparity in East Harlem, as an alarming 31% of its residents were obese and 13% were diabetic, with the mortality rate due to the latter condition twice as high as that for New York City as a whole (New York City Department of Health and Mental Hygiene, 2006). As I came to see, these problems were also plaguing Mexico.

A staple diet of rice, beans and tortillas, prepared with lard, may have been suitable for their hunter forefathers, but on our visit to Mexico, we were advised, and witnessed, that with greater food availability, less physically demanding work and more sedentary lifestyles, the rates of obesity and diabetes were on the rise. Genetic factors may also be involved. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has conducted research over the last 30 years on Arizona Pima Indians, a population that is descended from and genetically identical to Mexican Pimas. Around 50% of these adults have diabetes, and 95% of those with diabetes are overweight. A proposed *thrifty gene theory* that involves maintaining fat in

order to avoid starvation during times of famine may similarly be a contributory factor to modern Mexican descendants retaining unhealthy amounts of fat (National Diabetes Information Clearinghouse, 2002). To add insult to injury, because sugar-containing soft drinks are less expensive than drinking water, Mexicans have the highest consumption of Coca Cola beverages (60% of the Mexican soda market) per capita in the world. Moreover, despite the fact that Mexico is the world's largest producer of broccoli, this vegetable is nowhere to be found in Mexican cuisine (Saulnier, 2007; Workman, 2007).

In sharp contrast to obesity and diabetes, asthma, which was literally choking Spanish Harlem (23% of residents were affected), did not seem to be a problem for my Mexican patients (Diaz *et al*, 2000). Although asthma was the leading cause of emergency department visits and school absences among children in East Harlem, and the highest hospitalisation rate in New York City (ten times the national average), Mexicans seemed to be unaffected by the condition (Bonner *et al*, 2006). This pattern appeared to hold true for Mexican Americans beyond my clinic, as it was reported that Puerto Ricans had the highest asthma mortality among Hispanics, followed by Cuban Americans and Mexican Americans (Homa *et al*, 2000). Another study found that by comparison with Puerto Ricans in the USA, Mexicans had a lower asthma-related prevalence, morbidity and mortality (Burchard *et al*, 2003).

I learned that the lack of asthma among my Mexican patients was also replicated in their native setting. Mexico City, which has an altitude of 7200 feet, and a surrounding basin containing more than 30% of the country's industrial output, 3 million vehicles being driven each day, and widespread use of wood-burning stoves, ranks second only to Tokyo as the worst polluted territory in the world (Martinez, 2005). So it came as a great surprise, when I met a paediatrician at the NIH who was involved, as I was, in asthma care and research, to learn that this condition was rare, mild and that hospitalisations were generally non-existent. The aetiology of this apparent immunity to (severe) asthma is still being investigated.

Beyond specific conditions, I learned much about communication – one of the most important tools in a doctor's satchel. More than just words and grammar, it is enhanced by character and culture, and is the basis for effectively asking 'How may I help you?' and likewise for the patient giving the most productive answer.

At the risk of generalising, I learned that verbal and non-verbal communication between Mexicans is usually characterised by respect and formality, especially when addressing older people. Over-familiarity, whether physical or verbal, and judgemental attitudes are not

appreciated, especially early on in relationships, and this was amplified in the provider–patient bond. Disagreement with a healthcare provider was uncommon, and the more usual response in such a situation would be silence or non-compliance. This dynamic became a backdrop to other lessons that I was about to learn.

During discussions with physicians at NIH's respiratory division, I mentioned that at my clinic I would on occasion hear Mexican mothers describing their children with the phrase *demasiado tos* (literally meaning 'too much cough'). I had assumed that this description was dramatic, my biases rising to the surface, yet my host pointed out that such a comment reflected not so much hysteria as measured concern and stoicism, which are so deeply ingrained in Mexicans. Visiting a large general hospital and witnessing seemingly endless yet orderly lines of patients, where a typical day lasted up to 18 hours, after first travelling in the back of a truck for over 2 hours, just to receive a diagnosis, opened my eyes to this trait. A nursing supervisor described how an elderly, frail woman had been standing for hours upon end in order to be seen for a worsening ailment. When she fell down and broke her hip, she was put in a wheelchair and transported to the orthopaedic centre, only to be placed at the end of another protracted queue! The lesson was finally crystallised as I visited an outpatient chemotherapy ward. In this small room containing nearly 40 patients who were receiving powerful infusions, I was struck by an unfamiliar and eerie calm. Rather than moans and grimaces, as I expected, dignity and quiet resolve echoed throughout the room. Some patients were knitting, some were reading, some were speaking to their companions, and some were just patiently sitting.

Even as I visited these healthcare facilities, and learned how to better serve our own patient population, the landscape in East Harlem continued to dramatically transform. *Tacquerias* (taco shops) sprouted next to Puerto Rican *cuchifrito* (Puerto Rican soul food) shops, and *mariachi* (Mexican-style music or a type of musical band) was heard in the streets. Despite the hopefulness of this growing community, myriad problems remained. As they kept coming in large numbers, and were crammed into small apartments infested with rats, cockroaches and layers of mould, Mexicans found themselves not only socially isolated, but also caught in the crossfire of hostility between African-American and dominant Hispanic subgroups, as well as becoming direct victims of racism. Mexican gangs, such as *Vagos* (vagabonds) and *Mexican Boys* emerged, as did Mexican prostitution rings (Garland, 2003). One of my non-Mexican mothers confided in me her belief that these 'parasites' should go back to where they came from. This was not an isolated opinion.

Bringing lessons home

Hearing these stories and seeing for myself the structure of Mexican healthcare allowed me to begin to understand my patients' behaviours. Situations that were once confusing and difficult for me to explain were clearly rooted in the norms and expectations of health and healthcare in Mexico.

The latest chapter in this cross-continental curriculum instilled a broader and deeper feeling towards national entity, traditional culture and the existing healthcare structure, allowing me and my staff not only to begin to address needs more effectively, but also to reinforce healthy values and lifestyles. For example, Mexico's routine practice of breastfeeding, which occurs across all segments of its population until 3 years of age, became a model for all our clinic families. Through a series of departmental and hospital-wide presentations, I shared my newly acquired knowledge of the healthcare issues and concerns of the Mexican community of New York City, whose numbers increased by more than 50% between 2000 and 2004, and soon accounted for approximately one-third of the 120th Street Clinic's patient population.

Ongoing and effective outreach was important in order to strengthen the bridge to our new community. To achieve this, we relied on the Consulate, our main referral source and outreach post, and another soon-to-be partner, *Casa Puebla* ('home of Puebla') New York, whose mission was likewise to assist Mexican immigrants in assimilating into New York City. Together, we sponsored workshops at our clinic, local churches and the Consulate itself. The whys and hows of the US health delivery system were discussed, as well as specific conditions, including obesity and nutrition, alcohol and substance abuse, mental stressors and cancer. Since healthcare does not exist in a vacuum, experts were invited to speak about housing, language proficiency and education. Mexico's highly effective childhood immunisation registry, with families in that country being issued with laminated vaccination cards, served as a springboard to promote regular, preventive healthcare visits. We assisted in the Consulate's writing of a *Medical Guide for Mexicans*, which was published and distributed to Mexicans in the tri-state area (New York, New Jersey and Connecticut), containing information about and the rationale behind healthcare maintenance and screening examinations. We also assisted with the development of a '*Ventanilla de Salud*' (literally, 'window to health' – a health outreach programme) kiosk, stationed in the Consulate's lobby. In no small way these collaborations helped the Mexican community to settle into their life in New York City.

However, even with good intentions and new knowledge, the barriers to healthcare for any minority, disenfranchised population are formidable. Although

New York City is rich in resources for its poor, access has always been the rate-limiting factor. Additional impediments involving language and literacy, experience and ability to navigate systems, compounded by cultural beliefs, lack of education, and fear of interaction with agencies, specifically related to the threat of deportation, made this task even more difficult for Mexicans.

Appreciating the impact of cultural alliance, we employed a Mexican clerk who was a volunteer at the hospital. This staff member was not only comforting, but also served as an active and helpful link between the Mexican Consulate, Casa Puebla and the clinic. Remarkably, but consistent with the city's state of unpreparedness, there was not one Mexican attending physician throughout its public hospital system.

Our goal was to create a medical home for this community. This model first appeared in the literature in 1967, describing a 'place', and more recently a partnership approach with families in order to provide accessible, continuous, comprehensive, coordinated, compassionate and culturally competent care (Sia *et al*, 2004). This was indeed what I had built for my suburban patients. I was now working to build it for my East Harlem clientele, but this meant fine-tuning the model to meet their particular experiences and tastes. As this structure was being realised, patient trust and loyalty ensued.

In recognition and celebration, taking the lead from California's *La Clinica de La Raza*, the 120th Street Clinic was rededicated and renamed *La Clinica del Barrio* (the Clinic of the Neighbourhood). This process was led by a broadly represented community focus group which not only welcomed Mexicans, but also respected East Harlem's varied character. A local graffiti artist was commissioned to create, based on frescos at La Clinica de La Raza and the University of Mexico, Mexico City, a colourful and expansive mural combining scenes and stories from Mexico, as well as from the Barrio. Our once ordinary facility was converted into a bouquet of ethnic diversity. While planning the endeavour, a hospital administrator warned that the artwork would be vandalised. To this day, this has not happened. *La Clinica* became a name filled with affection, connection and community identification, recognised by HHC for its 'outstanding efforts in outreach to the Mexican community' (New York City Health and Hospitals Corporation, 2003), and by the State of New York Legislature for having a 'profound impact on the quality of healthcare and the dignity of life for the citizens of East Harlem, New York' (Mendez, 1999).

Since the late 1990s, the Mexican population has grown more quickly than any other group in New York City, and is reported to have increased by more than 50%, from 159 490 in 2000 to 244 411 in 2004 (New York City Health and Hospitals Corporation,



2005). Others have estimated that, taking into account undocumented individuals, more than 450 000 Mexicans were residing in New York City by 2005 (Bergad, 2005). *La Clinica* continued to serve and expand with the needs of Mexican New Yorkers, and to this day, as in the winter of 1998, it remains alert and nimble, ready to respond to changes and needs.

La Clinica del Barrio: a universal story

The Office of Minority Health defines 'culturally competent' healthcare as 'services that are respectful and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient populations' (US Department of Health and Human Services, 2008). Safety-net healthcare organisations are uniquely positioned to carry out this lofty mission. Building a patient-centred medical home was relatively easy in the white and wealthy suburbs of New Jersey. After all, being a native there, I knew who my patients were, where they came from and what they expected. Treating them as *I* would expect to be treated

was natural. In the pulsating streets of East Harlem, especially as Mexicans arrived, the tough charge of achieving cultural familiarity was undertaken. Based on personal relationships with providers and care teams, leading to trust, loyalty, compliance and a successful medical practice, the story of *La Clinica del Barrio* – translatable and replicable – can be told anywhere. It begins with recognition that the communities that are being served bring their own experiences, beliefs and expectations to the exchange. The goal is to build a medical home, but first one must understand what the patient wants from that home. Learning through communication with the providers in the native country and with others who have worked with similar immigrant groups can shape the foundation upon which this sturdy dwelling can be developed.

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CONFLICTS OF INTEREST

None.

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