urban areas.

To provide physicians appropriately trained and adequately motivated for this task, we need to create something new: a public-sector, public-interest medical school explicitly committed to this task that unites a public university, public hospitals, and community health centers as teaching sites; includes a health department; and provides a curriculum that is enriched in both the biomedical and behavioral dimensions appropriate to the needs of the target population. To provide a support structure for continuing practice in underserved areas, we need an Urban Health Corps with funding adequate to ensure decent salaries, professional fulfillment, and continuing medical education throughout a 5- to 10-year service period. Finally, we need the restoration of services removed by the devastating cuts in the community health center network. The costs of all this would be more than offset by the savings in hospitalization—and in productive lives.

There is an analogue—the Uniformed Services University of the Health Sciences, Bethesda, Md. Our nation's security depends no less on the protection of our domestic health. And there is already a precursor: the City University of New York (NY) Medical School, located in central Harlem and drawing on the underserved population itself—a vast, untapped human resource—for its student body. Our experience demonstrates that, even in the midst of deprivation and epidemic, there is no shortage of able, committed students who want to serve.

H. Jack Geiger, MD
The City University of
New York (NY) Medical School

To the Editor.—My wife and I operate a free clinic that might serve as one model for provision of medical care to the uninsured. The clinic provides basic primary care and pediatric immunizations to people who cannot afford $50 for a blood pressure check or $100 for shots.

It is open one night a week in the office of a local Hispanic community organization, and 15 to 20 patients are seen each night. They are screened for ability to pay, but almost everyone is accepted; a donation of $1 to $5 is encouraged. There are two to four volunteer physicians, one or two volunteer nurses, one or two volunteer secretaries, and one or two paid translators. Modest overhead costs are paid. The budget is under $10 000 a year, or about $10 per patient visit. Start-up costs for basic office equipment were about $3000, given by Warner Lambert. We also have grants from United Way and the Robert Wood Johnson Foundation.

About 20 local physicians in various specialties have agreed to see referrals for no fee or a reduced fee, and patients are also referred to the local hospital clinics, for example, the prenatal clinic. At the hospital they are screened and pay on a sliding scale: up to $100 a visit.

We perform urine tests, measure hemoglobin and blood glucose levels, and carry out pregnancy tests. Roentgenograms and other laboratory work are performed at the hospital. Prescriptions are filled at a local pharmacy that has agreed to give discounts. A local optometrist provides glasses at cost. The emphasis is on basic, no-frills medicine. Tests are ordered sparingly, and a drug supply house catalog is used to check on the cost of medications. Immunizations are supplied free by the state. Because of our low overhead, services can be provided much more cheaply than in the hospital clinics, and the hospital is relieved of a financial burden.

We are ourselves volunteers, and to some extent we depend on volunteers. Medical care for the uninsured is going to take either a lot of money or a lot of volunteers. There's still a little public and private money around, and, with proper organization and encouragement, there may be enough volunteers.

Robert Zufall, MD
Dover, NJ

To the Editor.—San Francisco, Calif, is currently "home" to an estimated 6000 to 10 000 people with no place of their own to live and sleep. Currently available medical resources are not adequate to meet the needs of these people, due to financial or geographic barriers. Even with an existing network of public clinics and health care visits in homeless shelters, many go without needed care.

In 1988, the San Francisco Department of Health and San Francisco Medical Society embarked on a partnership aimed at filling this gap. An arrangement was made whereby the Department of Public Health would provide liability coverage for any physician or other health care provider who volunteered his or her services for the city's homeless program, and the local medical school would provide teaching credit to clinical faculty members who provided care while supervising medical residents.

The next step has been to recruit volunteers, and two meetings at the medical society drew large numbers of nurses and lesser numbers of physicians. Subsequent calls for volunteers have gone out in local medical and lay publications. Approximately half a dozen physicians have followed through in providing volunteer services, and one dermatologist has been conducting a very well-received monthly clinic for the past 2 years.

There is need for more physician volunteers. The lure of liability coverage and teaching credit has not been as attractive as hoped, nor has offering to schedule clinic times at the discretion and convenience of the volunteer. We are now considering developing a list of physicians who would see a predetermined number of homeless patients in their own offices, and then providing appropriate patients with those physicians' business cards after initial assessment at the public clinics.

Homeless people as a group have a high prevalence of medical and mental health problems, but many, if not most, of such problems can be dealt with in the provision of basic primary and preventive care.[1] The most immediate need, therefore, is for a larger number of physicians who consider this kind of public service a part of the privilege and responsibility of their profession.

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San Francisco (Calif)
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1. Wlodarczyk D, Prentice R. Health issues of homeless persons. *West J Med.* 1988;148:717-719.

To the Editor.—I practice with a multispecialty group in a city with a population of 25 000. Our group draws from a regional population base of approximately 100 000. All of our physicians but one have both office- and hospital-based practices. Our accounts department screens patients for us so that elective services are provided only to patients who have resources to cover the cost of the service. Individual physicians may, at their discretion, opt for less stringent screening standards. Hospital services are provided by physicians on an urgent or emergency basis almost entirely without knowledge of, or consideration for, a patient's ability to pay. Despite our taking steps to limit elective services for underinsured and uninsured patients, our group wrote off over $1 million in services as uncollectible in the fiscal year 1990. This amounted to over $50 000 per practitioner! One can only wonder how staggering the write-off might have been had some sort of screening policy not been adopted. As sizable as it is, the financial write-off is only a footnote to the stress, sleep deprivation, health risks, and liability incurred in caring for these patients.

I use the above data to support my contention that physicians already resemble White Knights rather than