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The Tufts-Delta Health Center and the Limits of Maximum Feasible Participation, 1965–1970

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SUMMARY: Founded in 1965 during the War on Poverty, the Community Health Center (CHC) program was created to meet the health needs of poor Americans while employing patients in clinic oversight and operations. This study explores the historical roots and implications of community participation in health care. The paper focuses on the foundational years of the CHC program, with attention to the establishment of the Tufts-Delta Health Center (TDHC) in Mound Bayou, Mississippi, and the struggles to realize community control in a clinical context. The analysis reveals the tensions between outsider activists, local elites, and impoverished community members over CHC governance, reflecting broader conflicts over community participation in health care. By scrutinizing the practical and ideological conflicts at TDHC, this essay illuminates the promises and limitations of federal grassroots health initiatives and underscores the complexities of genuine patient authority in health care delivery.

KEYWORDS: community health centers, social medicine, Jack Geiger, war on poverty, community health

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Answering Ana Dumois

In remarks titled the "Place and Value of the Neighborhood Health Center in the Medical Care Delivery System," given in 1969, New York City social worker Ana Dumois asked, "Who is the consumer? Who represents the consumer?"[1] By "consumer," Dumois meant health center patient. The community health center (CHC) program that was the subject of Dumois's address began in 1965 as a War on Poverty effort to spur a grassroots transformation in health care delivery. Dumois's use of the word "consumer" reflected what was already known, in 1969, as the "consumer governance mandate": the requirement that CHCs—federally funded clinics serving many of the poorest Americans—incorporate significant oversight from the communities they served.[2] This mandate stemmed from multiple sources. Most immediately, it was an effort to instantiate the Economic Opportunity Act (EOA) of 1964's requirement that War on Poverty projects involve the "maximum feasible participation" of target populations. More generally, as this paper traces, it was an evolution of a concept of community involvement in health care that emerged from decades of health reform in the first half of the twentieth century.

As quickly as Dumois posed her seemingly straightforward query—Who is, and who represents, a health center patient?—she sidestepped the answer. "We don't have time tonight to explore the question fully for it would require a whole session." Dumois permitted herself a single, telling aside. "I don't want consumer involvement for its own sake. I want consumer

[1] Ana Dumois, "Place and Value of the Neighborhood Health Center in the Medical Care Delivery System," May 14, 1969, transcript from the University of Minnesota Social Welfare Archives (SWHA), Helen Hall Papers (HH), box 80, folder: Health, General, 1934–1969.

[2] The precise definition of consumer governance was an evolutionary process; in the 1970s it was formalized as a requirement that at least 51 percent of health center boards be composed of clinic patients.

involvement to be effective in influencing the re-structuring of the system and in order for the consumer to be effective he needs knowledge and organization." This paper takes up Dumois's implied tension between "consumer involvement for its own sake" and the existing health care power structure, as seen through the case study of one of the first CHCs, the Tufts-Delta Health Center in Mound Bayou, Mississippi.

In 1965, the Office of Economic Opportunity (OEO), a War on Poverty creation, supported the efforts of three Boston physicians, H. Jack Geiger, Count Gibson, and John Hatch, to establish the first two CHCs—one in Boston and one in the Mississippi Delta. Geiger, Gibson, and Hatch sought to create a clinical model aimed equally at treating the individual burden of disease and its socioeconomic determinants.[3] CHCs were intended to deliver essential primary care health care to poor Americans while providing a host of other social services, including employment, job training, housing resources, food cooperatives, and more.

A defining feature of the War on Poverty policy was the mandate for "maximum feasible participation" of target communities in poverty-alleviating programs.[4] CHCs, building on decades of activism that argued for a community role in health care, fulfilled this mandate by selecting consumer boards to administrate individual health centers. The belief was that patient control of health care would not only meet the self-articulated needs of the community but

[3] Alice Sardell, "Neighborhood Health Centers and Community-Based Care: Federal Policy from 1965 to 1982," *J. Pub. Health Policy* 4 (1983): 484–503.

[4] For a discussion of legal foundations of this mandate, see Tara J. Melish, "Maximum Feasible Participation of the Poor: New Governance, New Accountability, and a 21st Century War on the Sources of Poverty," *Yale Hum. Rights Dev. Law J.* 13, no. 1 (2010): 1–134. For grassroots implementation, see Annelise Orleck, "Introduction: The War on Poverty from the Grass Roots Up," in *The War on Poverty: A New Grassroots History*, ed. Annelise Orleck and Lisa Gayle Hazirjian (Athens: University of Georgia Press, 2011), 1–28.

empower patients as civic and economic actors. Beyond the theoretical benefits of civic empowerment, control of clinic operations brought the tangible benefits of employment and patronage opportunities. At the federal level, however, "maximum feasible participation" was left largely undefined. Determining the scope of community control in the health care setting was deferred to local interest groups who often competed for War on Poverty dollars.

The first section of this paper explores the emergence of CHCs from the Progressive Era to the 1960s, tracing the work of labor activists, social reformers, and their distinct notions of community participation in health care. Operating under overlapping but discrete concepts of community formation, various groups converged on the idea that consumer involvement in health centers could democratize health delivery and alter the social determinants of health. Competing notions of community informed competing notions of community oversight. The question of who constituted a health center patient became a question of who controlled the jobs, medical services, and organizing capacity represented by the clinic. Empowering poor people in health care entailed power sharing with groups unfamiliar with any dilution of social influence, from physicians to local elites and policymakers. It is no surprise, therefore, that the question "Who is a consumer?"—and by extension, who oversaw health centers—was so vexed.

The second section provides an explication of the ambiguities and implications of "maximum feasible participation," while sketching the political context that enabled federal support of CHCs during the War on Poverty. "Maximum feasible participation" represented an ambitious but vaguely defined directive to involve poor communities directly in antipoverty policy implementation. Its execution faced significant challenges due to resistance from established political entities and a lack of clear guidance regarding what constituted appropriate

levels of participation. Varying interpretations of the mandate created conditions for conflict between parties seeking to either secure federal funding or preserve preexisting power structures. As a result, the imprecision of its definition ultimately hindered the achievement of "maximum feasible participation's" democratic objectives.

The third and final section of the paper offers a case study of the Tufts-Delta Health Center (TDHC) in Mound Bayou, Mississippi, one the first federally funded CHCs. The efforts—sometimes collaborative, sometimes conflicting—of activists, local elites, OEO administrators, and impoverished townspeople to influence TDHC's trajectory illustrate the promises and pitfalls of "maximum feasible participation" in a clinical setting. By situating TDHC in the broader context of the domestic health center movement and the War on Poverty, this paper illuminates the attendant complexities of federal support for grassroots action in social service delivery.

This essay dissects divergent claims to control TDHC in its founding period, 1965 to 1970, exploring the struggles between competing stakeholders acting in the name of Mound Bayou's community. In particular, this paper argues that at TDHC well-intentioned reformers relied on mystified notions of community as a one-size-fits-all model that obscured the diversity and specificity of the people TDHC was meant to serve. Two forces—the legal ambiguities surrounding "maximum feasible participation" and activists' assumptions regarding the Mound Bayou public—created conditions for conflict between local and outsider actors holding distinct notions of "community" and its role in clinic governance. This conflict, coupled with inconstant OEO support, destabilized the clinic's operating environment and undermined TDHC's ability to achieve "maximum feasible participation," however vaguely defined. While TDHC possessed

radical implications for the people it served, it lacked secure operating conditions—enjoying neither steady federal support nor sufficient buy-in from local power brokers—in which to achieve its social ambitions.

The Emergence of Community Health Centers

Although the first federally supported CHCs were established in the mid-1960s, the roots of a health center movement in the United States stretch at least to the Progressive Era. Progressive Era reformers, championing sanitation measures to serve the nation's rapidly expanding urban population, established neighborhood clinics that "brought together such social services as infant care and well-baby stations, settlement houses, hospital outpatient departments, tuberculosis clinics, and venereal disease treatment."[5] These centers embodied a form of charity care that treated the medical consequences of poverty, immigration, and urban overcrowding. While their leaders recognized that social circumstance was often the ultimate etiology of illness, early health centers focused on treating poverty's sequelae rather than the thing itself. It would require multiple forces, including the failure of national health insurance efforts and the grassroots mobilization of labor and civil rights activists, to achieve a reimagination of health centers as a vehicle for political formation and community empowerment.

The Great Depression drew renewed attention to the question of health care for the poor, and limited Public Works Administration funding was allocated to the construction of

[5] Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, N.J.: Princeton University Press, 2006), 131.

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neighborhood health centers across the country.[6] The Social Security Act of 1935 included provisions for public health, child welfare, and disability benefits, but more significant reforms soon stalled at the federal level. By 1935, the Roosevelt administration dropped its support of a national health insurance program in the face of opposition from Congress and the medical establishment. Labor activists adopted the cause of local health plans—progenitors of modern private insurance—in lieu of elusive national reform. Health centers were envisaged as the physical embodiment of health plans' comprehensive offerings. Reformers "embraced a new concept, the health center as a general medical treatment center . . . [where] patients could obtain diagnostic, therapeutic, and preventive medical care; they could see general physicians, technicians, and specialists in one place."[7]

While labor had historically focused on securing gains for its members, there was an increasing recognition that health was "a social as well as an individual concern."[8] Some activists, working within the tradition of what Elizabeth Faue calls "community-based unionism," sought to create clinics serving the entire communities in which union members, not only the laborers themselves, lived.[9] In 1945, for instance, the American Association of Health Workers, a branch of the American Labor Party (itself a Socialist Party of America offshoot), recognized that "the health security for all the people is an integral part of the program for full-employment, peace and security." To that end, they called for local health systems to operate

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[6] John Rice to Helen Hall, February 15, 1934, SWHA, HH, box 80, folder: Health, General, 1934–1969.
[7] Klein, *For All These Rights* (n. 5), 131.
[8] Ibid., quotation from the *American Federationist* on 118.
[9] Elizabeth Faue, *Community Suffering and Struggle: Women, Men, and the Labor Movement in Minneapolis, 1915–1945* (Chapel Hill: University of North Carolina Press, 1991), 1–20.

clinics as an "integrated whole," offering access for all residents to "the services of [a] physician and medical specialist, dentist, optometrist, podiatrist, nurse, social worker, nutritionist, and other recognized health and welfare practitioners."[10]

While working people's advocates galvanized a movement toward neighborhood health centers, certain doctors' associations supported their own versions of the model. Such groups advocated for top-down, physician-led community health plans intended to serve the basic needs of working people. While remaining skeptical of national health plans and government-funded care, such groups were nonetheless radical for the time in their support of a community-based model of health care delivery. These groups existed outside of the mainstream medical establishment, which feared the diminution of physician autonomy or remuneration that more public-health-focused measures might entail. One prominent example of a physician-led health plan was the Medical Society of the County of New York's sponsorship of an "experiment in medical care of poor in low-cost housing development" in 1940.[11] The plan offered low-income residents of the Lower East Side's public Vladek Houses access to primary care services, paid for with a twenty-five-cent charge per resident added to their rent. George Baehr, the plan's author, couched its benefits in terms of individual uplift and as a hedge against poor people's suspected preference for government-provided care. "It is an experiment in teaching the poor how to use a general practitioner and how to set aside a small amount of money. . . . The experiment presents

[10] "Notes for Chairman," Public Forum of the Health Council of the American Association of Health Workers, May 24, 1945, memorandum, SWHA, HH, box 80, folder: Health, General, 1934–1969, 1971.
[11] "Outline of Proposed Experiment in Medical Care of Poor in a Low-Cost Housing Development," Activities of the Medical Society of the County of New York, March 23, 1940, abstract, SWHA, HH, box 83, folder: Health—Corlears Hook Medical Association, 1939–1940.

an opportunity to retrain a group of poor people who have been accustomed to take for granted a completely paternalistic attitude of the government and teach them the superiority of private medical care."[12] While Baehr's plan addressed pressing medical needs, the proposed experiment was an imposition from above, rather than a response to community demands. Perhaps because his plan to "retrain" poor people's relationship to health care was itself emblematic of the paternalism that Baehr claimed to deprecate, the experiment foundered within a few years. Tensions between physicians' often paternalistic conception of community health and communities' own articulation of their needs would persist in the coming decades.[13]

As health centers expanded their patient panels and increased the number of services on offered, they enlarged their ambitions for what a health center might accomplish. Increasingly, communities viewed clinics as engines for economic empowerment and political formation. In the 1950s and 1960s, the Gouverneur Ambulatory Care Unit of Beth Israel Hospital on Manhattan's Lower East Side was a notable example of this model of clinic as community development. Gouverneur Hospital had opened as a municipal infirmary in 1885 and served successive waves of migrant working-class communities on the Lower East Side. In the 1950s, after years of disinvestment, a state commission recommended Gouverneur's closure. This set off a wave of organizing, spearheaded by the Lower East Side Neighborhood Association (LENA), a coalition of trade unionists, community organizers, refugees, educators, and clergy who advocated for community oversight of neighborhood health infrastructure.

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[12] George Baehr to Francis Kimball, May 3, 1940, letter, SWHA, HH, box 83, folder: Health—Corlears Hook Medical Association, 1939–1940.

[13] For further reading, see George Baehr, "Health Insurance Plan of Greater New York: The First Three Years," *JAMA* 143, no. 7 (1950): 637–64.

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In 1961, owing largely to LENA's advocacy, the state merged Gouverneur with nearby Beth Israel Hospital to create the Gouverneur Ambulatory Care Unit of Beth Israel Hospital, which would eventually receive funding as one of the earliest War on Poverty–era CHCs.[14] Even before achieving that designation, Merlin Chowkwanyun has argued it operated on an essentially similar model of community-engaged care: "Gouverneur blurred the boundary separating the clinic from its patient pool, employing community organizers and door-to-door health workers—most from the neighborhood itself—to gauge common problems in the area and encourage more use of its services."[15] Organizers remained committed to an inclusive notion of community. Clinic services were routinely described in handwritten, mimeographed bilingual pamphlets to keep the neighborhood's Puerto Rican population informed. Underlying their efforts was activists' belief that community oversight of health care enabled political formation and improve health outcomes. In May 1964, LENA organized a health fair that included discussions of Gouverneur's leadership and future direction as well as exhibits offering housing and employment resources, free chest X-rays, and one booth that explicitly articulated the link between individual and neighborhood health: "Your Welfare Means a Stronger Community."[16]

Across the country, grassroots groups worked to refine distinct yet overlapping models of health centers. From the 1930s to the 1960s, an alliance of reformers, spearheaded by organized

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[14] Howard J. Brown and Raymond S. Alexander, "The Gouverneur Ambulatory Care Unit: A New Approach to Ambulatory Care," *Amer. J. Pub. Health Nation's Health* 54 (1964): 1661; Merlin Chowkwanyun, *All Health Politics Is Local* (Chapel Hill: University of North Carolina Press, 2022), 28–46.

[15] Merlin Chowkwanyun, "Biocitizenship on the Ground: Health Activism and the Medical Governance Revolution," in *Biocitizenship: The Politics of Bodies, Governance, and Power*, ed. Kelley Happe, Jenell Johnson, and Marina Levina (New York: New York University Press, 2018), 180.

[16] "Health Fair—1964," May 12, 1964, program, SWHA, LENA, box 2, folder: Health, 1960–1965.

labor, solidified the outlines of a health center that served the needs of working people and viewed community participation as indivisible from community health. Operating in this context was H. Jack Geiger, a physician-activist who would eventually win federal support for CHCs during the War on Poverty. While Geiger was a native New Yorker, his personal journey studying overseas health systems illustrates the concomitant foreign influence upon the United States' homegrown community health movement.

During Geiger's final year of medical school, in 1957, he spent four months in South Africa working with Drs. Sidney and Emily Kark. His stay in South Africa was brief but formative—he later described it as the "seminal event" in developing his understanding of community health care.[17] The Karks were practitioners of what they termed "community-oriented primary health care," which Geiger, in a later encomium, defined as "the merger of frontline clinical medicine with public health . . . [integrating] personal curative and preventive medical services, demographic study, epidemiologic investigation, community organization, and health education."[18] Notably, the Karks employed many of their patients in their clinics.

During Geiger's clerkship at the Karks' Institute of Family and Community Health, he first began to grasp the interplay of culture, class, and race upon health. His early insight was that health centers provided a forum for political formation. Through door-to-door outreach, local residents—barred from social citizenship under the apartheid regime—could learn to see

[17] "H. Jack Geiger Oral History Interview, Primary Care Development Corporation in New York, N.Y. on November 13, 2017," transcript, https://www.pcdc.org/public-health-pioneer-conversation-dr-jack-geiger/ (accessed April 14, 2023).
[18] H. Jack Geiger, "Community-Oriented Primary Care: The Legacy of Sidney Kark," *Amer. J. Pub. Health* 83 (1993): 946–47.

themselves as members of the civic bodies the clinics served. Of his work in South Africa, Geiger later remarked, "The influence of culture, social structure, and environment on health status . . . was all the more apparent because all three were to my non-African eyes, exotic."[19] He had to step out of his native context to appreciate the interplay of social context and health outcomes. "I had the opportunity to acquire my sense of community structure and function by seeing patients in their community—in their homes, in schools, in clusters of huts on rural hilltops."

After returning to the United States, Geiger became increasingly involved in civil rights advocacy. During 1964's Freedom Summer he provided medical care to activists registering Black voters across Mississippi. In December 1964, Geiger attended a meeting sponsored by the Delta Ministry of the National Council of Churches to discuss ways to transform public support for civil rights into sustained investments in community development. Geiger later recounted, "At that moment—I don't know what took me so long—for the first time I remembered . . . South Africa, and the root discipline of community-oriented primary care."[20] The similarities between South Africa and the Delta seemed obvious: racial segregation, grinding poverty, state-sponsored violence. Geiger's thoughts turned to what he described as the "pipe dream" of creating for Black Mississippians what the Karks had for Black South Africans.[21]

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[19] H. Jack Geiger, "The Meaning of Community Oriented Primary Care in the American Context," in *Community Oriented Primary Care: New Directions for Health Services Delivery*, ed. Eileen Conner and Fitzhugh Mullan (Washington, D.C.: National Academies Press, 1983), 60–61.
[20] "H. Jack Geiger Oral History Interview" (n. 17).
[21] Ibid.

Geiger's experience in South Africa served as an individual epiphany of the benefits and possibilities the neighborhood health center. To a certain extent, Geiger's journey would become—through his and others' retelling—the dominant founding narrative in the history of CHCs: the "exotic" insights gleaned abroad and imported home, driving the founding visionary to his idealistic project. It does not diminish the importance of this personal influence for Geiger's subsequent CHC advocacy to acknowledge the deeper history of neighborhood health centers, whose possibilities had long been appreciated by reformers closer to home. For decades, activists had sought to extend health security to marginalized populations, embodied by neighborhood clinics controlled by the communities they served. The concept of health centers had disparate roots—distinct yet intersecting nodes in a broader reform movement that converged on the concept of CHCs as a solution to pressing public health needs. In reimagining the health center as a citizen-controlled space of political formation, activists battled the physicians' groups, hospital administrators, and other powerful incumbents who opposed democratic reforms in community health. The efforts of these activists across a multidecade span helped created the necessary political circumstances for a federal experiment in neighborhood health centers.

Bringing "Maximum Feasible Participation" to Mississippi

Lyndon Johnson's War on Poverty, initiated in 1964, was among the United States' most ambitious attempts to alleviate poverty through federal intervention. While eventually Johnson, his successors, Congress, and the federal judiciary would dilute many of the most ambitious initiatives, the enormous scale and rapid pace of the program's first few years created an

atmosphere of policy experimentation in which solutions to fundamental social challenges were pursued with bureaucratic vigor. This brief window of policy experimentation, coupled with generous federal largesse, provided the opportunity for activists to establish the first federally supported CHCs.

As a key mechanism for enacting locally responsive antipoverty policy, 1964's EOA authorized Community Action Programs (CAPs), which would serve as coordinating bodies for communities to provide input to OEO's antipoverty initiatives.[22] Operating under the theory that local groups were best positioned to define their economic needs, CAPs supported marginalized groups with federal dollars and administrative oversight. Advocating for EOA's passage, three months before it was signed into law, President Johnson outlined his vision for Community Action as a new kind of partnership between the federal government and grassroots organizations: "The solution to these [economic] problems does not rest on a massive program in Washington, nor can it rely solely on the strained resources of local authority. They require us to create new concepts of cooperation, a creative federalism, between the national capital and the leaders of local communities."[23]

Health provision was not an initial focus of the War on Poverty. Early on, OEO focused on promoting community development and economic mobility through programs such as Job Corps, VISTA, and Head Start. Yet administrators soon began receiving requests from community partners to fund health screenings and other primary care services. OEO decided that

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[22] Melish, "Maximum Feasible Participation of the Poor" (n. 4), 4.

[23] President Johnson, Remarks at the University of Michigan, May 22, 1964, transcript, 1 PUB PAPERS 704, 706, http://www.lbjlibrary.net/collections/selected-speeches/november-1963-1964/05-22-1964.html (accessed February 22, 2024).

to fulfill their economic mission they would need to simultaneously address the health of target populations, allotting 11 percent of their Community Action funding to health-related causes in 1965.[24]

By that time, Geiger was a professor at Tufts University Medical School. Alert to OEO's receptiveness to health-focused proposals, Geiger and his colleague Dr. Count Gibson proposed a local health center model that could be distributed nationally.[25] Under this model, health centers would pursue primary care delivery while involving community members through direct employment and operational oversight. Their emphasis on community oversight consciously evoked Title II of EOA, which called for the "maximum feasible participation" of local community members "in the development, implementation, and administration of programs aimed at eliminating the causes of poverty."[26] EOA's authors understood that antipoverty measures required both top-down federal investment and bottom-up community engagement. However, EOA gave little guidance on how "maximum feasible participation" was to be defined or accomplished. With money in hand, it was left to grantees to translate Johnson's "creative federalism" to a clinical context. What were the means by which a community might oversee health delivery? Although activists in the health center movement had spent decades demonstrating solutions to this question, "the operationalization of [maximum feasible

[24] Greta de Jong, "Plantation Politics: The Tufts-Delta Health Center and Intraracial Class Conflict in Mississippi, 1965–1972," in Orleck and Hazirjian, *War on Poverty* (n. 4), 257.
[25] Notably, Gibson was the first physician to raise public concerns related to the government's Tuskegee Study of Untreated Syphilis in the Negro Male, seventeen years before its discontinuation.
[26] Melish, "Maximum Feasible Participation of the Poor" (n. 4), 4.

participation]" in CHCs was, as Alice Sardell has shown, "an evolutionary process which . . . involved conflict between health center consumers and administrators."[27]

The core challenge of "maximum feasible participation" as policy was that its ambitions to directly involve poor communities in antipoverty programming were matched only by the ambiguities of its scope and intent. Practical implementation proved difficult due to local resistance from established political players, lack of clear elaboration for what constituted "maximum" or "feasible" participation, and tension between professional expertise and community knowledge. While the concept marked a significant departure from traditional top-down social welfare approaches, its deliberately open-ended phrasing—chosen in part to navigate complex political considerations—led to varying interpretations across localities, which spurred intractable debates about the appropriate balance between professional administration and community control, ultimately contributing to the program's operational challenges. Some OEO grantees interpreted the "maximum feasible participation" mandate minimally, establishing token advisory boards with limited influence, while others embraced more radical approaches that challenged existing power structures. Thus, "maximum feasible participation" served simultaneously as a radical policy ambition and, given the intrinsic instability of its competing interpretations, an impediment to achieving the democratic spirit of that ambition.

Despite their soaring rhetoric, Johnson and OEO began to walk back their ambitions for Community Action soon after EOA's passage in August 1964. This was partially in response to leaders across the country—mayors, governors, political bosses—who feared loss of influence in the local deployment of federal dollars. Additionally, the Johnson administration was anxious

[27] Sardell, "Neighborhood Health Centers and Community-Based Care" (n. 3), 488.

that they had created a too-powerful grassroots political force, open to radical influence and outside of federal control. As early as late 1964, President Johnson was telling members of Congress in private, "to Hell with Community Action" and informing his advisors that CAPs were only a peripheral feature of War on Poverty policy.[28]

While the Johnson administration and, by extension, OEO soon sought to decenter CAPs and the "maximum feasible participation" mandate, activists continued to identify ways to exploit their potential. For Geiger and Gibson, "maximum feasible participation" substantiated the principle of community control in health care, a principle to which they remained dedicated regardless of the Johnson administration's shifting attitudes. While he would later temper some of his boldest claims about CHCs, these were heady days, and Geiger echoed the Johnson administration's grandest rhetoric when describing his ambitions for the new clinics. "The ultimate goal" of the early CHC movement, as Geiger later described it, "was to establish pathways out of poverty and into a better life."[29] The indissoluble means by which CHCs could achieve this social transformation, Geiger believed, was through patient participation in health delivery.

OEO approval for two trial clinics came quickly. Geiger and Gibson soon teamed up with Dr. John Hatch, an African American colleague from the Deep South. In a politically shrewd choice to bridge rural-urban and North-South divides, the first clinic locations were in Mound Bayou, Mississippi, and Columbia Point, Boston. Geiger and Hatch were installed at Mount

[28] Orleck, "Introduction" (n. 4), 15.
[29] H. Jack Geiger, foreword to Thomas Ward, *Out in the Rural: A Mississippi Health Center and Its War on Poverty* (Oxford: Oxford University Press, 2017), xii.

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Bayou and Gibson at Columbia Point. Other teams from around the United States began submitting similar proposals, and six additional centers were funded by the end of 1965.[30]

By the summer of 1965, Geiger and Hatch had secured sponsorship for the Mound Bayou clinic from their employer, Tufts University. The choice of Mississippi proved politically challenging as, Geiger said, "we knew that all of the South . . . would furiously resist any intervention from outside."[31] They faced an early obstacle when Governor Paul Johnson threatened to prevent the project from breaking ground. Under EOA, governors retained the prerogative to veto any OEO project in their states. In Geiger's telling, the institutional imprimatur of a Massachusetts university proved indirectly vital for overcoming opposition to the establishment of a Mississippi clinic. Half a century later, Geiger detailed his team's side-stepping of southern impediments to the first health centers:

> But then the Southern states decided that if [schools such as] Ole Miss and the University of Alabama could tap into some of that OEO money, then [a Southern state] could get access too. So, they agreed to a stipulation that grants to institutions of higher education be exempt from veto, so that Ole Miss and others could profit. It had never occurred to anybody . . . that a grant could be made to an institution of higher ed in Boston to do something in Mississippi. We just reinvented carpetbagging, in effect.[32]

While it was apparent that Mississippi's establishment was arrayed against the project—the state's medical association president remarked, "[I am] shocked to learn the federal government is seriously considering employing Tufts Medical School to provide comprehensive health services in Mississippi"—in practice the state had little ability to oppose it.[33] OEO funds

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[30] Sardell, "Neighborhood Health Centers and Community-Based Care" (n. 3), 485.
[31] "H. Jack Geiger Oral History Interview" (n. 17).
[32] Ibid.
[33] Ward, *Out in the Rural* (n. 29), 16.

were composed of federal dollars, and its director Sargent Shriver could reverse any southern veto. As one analyst noted, "It was not uncommon for southern governors to veto OEO grants only to be overridden by Shriver. In fact, Shriver overrode almost all vetoes."[34]

Geiger's telling, with its emphasis on institutional "carpetbagging," heightens the sense of precarity in the clinic's early days while accentuating activists' cunning in the founding of the new health center. Acknowledging the more modest reality that OEO could launch initiatives regardless of Southern opposition does not diminish the courage required to pursue civil rights in 1965 Mississippi. Never far from any of the Mound Bayou activists' minds were the previous year's murders of James Chaney, Andrew Goodman, and Michael Schwerner near Philadelphia, Mississippi—another activist union of Black locals and white northerners. While Geiger may have overstated the degree to which the reinvention of "carpetbagging" was key to the establishment of the Mound Bayou clinic, the clinic's emergence was nonetheless contingent on the ability of physician-activists, local leaders, and federal sponsors to respond to a unique window of political opportunity during the War on Poverty.

The Tufts-Delta Health Center

From the time of its founding in 1887, Mound Bayou, Mississippi, was an exemplar of Black autonomy in the Jim Crow South. Tucked along the eastern border of Bolivar Country—named for the legendary Venezuelan *Libertador*—it was established by Isaiah T. Montgomery and a

[34] G. David Garson, "Economic Opportunity Act of 1964," memorandum, Merced County Community Action Agency, https://www.mercedcaa.com/v2/wp-content/uploads/2018/11/Economic_Opportunity_Act_of_1964.pdf (accessed March 17, 2024).

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group of fellow freedmen that had formerly been enslaved by members of Jefferson Davis's family. An all-Black town, the tiny community—around 300 residents in the 1900 census, peaking around 3,000 eight decades later—was self-conceived as an oasis of Booker T. Washington–influenced "racial uplift." In its first decades, farmers prospered in cotton and timber and, in some cases, built significant land holdings in the surrounding area. President Theodore Roosevelt, visiting in 1908, called Mount Bayou "an object lesson full of hope for the colored people and therefore full of hope for the white people, too."[35] In a subsequent address in 1912, the then-former president hailed the town as a "place where a Negro may get inspiration by seeing what other members of his race have accomplished."[36] With time, townspeople established a credit union, normal school, fire station, and the first swimming pool for Black residents in Mississippi. Yet for all the self-sufficiency and civic optimism embodied by Mound Bayou's residents, racial limitations on credit, falling cotton prices, and the pressures of agricultural mechanization pushed increasing numbers of residents from independent enterprise into the enormous physical and financial burdens of sharecropping.

Segregation and poverty limited local access to medical care, and residents took up the cause of health care delivery with their typical enterprising attitude. In 1942, a prominent local fraternal order, the International Order of the Twelve Knights and Daughters of Tabor, founded the Taborian Hospital. It possessed an all-Black staff and was led by Theodore Roosevelt Mason Howard, eventually to become one of Mississippi's wealthiest Black residents and a noted civil

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[35] David Beito, "How Little Mound Bayou Became a Powerful Engine for African American Civil Rights and Economic Advancement" (Independent Institute, 2023), https://www.independent.org/news/article.asp?id=14693 (accessed March 10, 2024).
[36] Ibid.

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rights activist.[37] Dr. Howard was lauded by many in the community for his entrepreneurial spirit and philanthropy; he was also criticized for allegedly extortionate pricing of medical procedures. Moreover, Taborian Hospital, within two decades of its founding, became notorious for its decaying facilities.[38] With time, there emerged a tension between locals who felt excluded from Mound Bayou's successes—mostly penurious sharecroppers in the surrounding rural area—and those in the local middle class who felt that they were the town's natural leaders. Yet the term "middle class"—used by locals at the time—obscures the degree to which this group was also, by standards relative to much of the country, impoverished: class tensions in Mound Bayou were, in some respects, a narcissism of small differences. As the local economy struggled throughout the twentieth century, these tensions became further inflamed. By the 1960s, Mound Bayou was simultaneously emblematic of the possibilities of Black liberation and of the political, economic, and medical constraints with which the state fettered those possibilities. By the 1960s, the town had experienced decades of hardship, and residents of all backgrounds complained of malnutrition, poor sanitation, and unsafe housing in Mound Bayou. Despite these hardships, much of the civic architecture in the town remained intact. Its strong civic culture and proud history, coupled with its urgent material needs, made Mound Bayou an ideal location for the federal government to begin its experiment in CHCs.

After securing OEO funding in late 1965 and identifying Mound Bayou as a suitable location in 1966, the Tufts-Delta Health Center (TDHC) required a physical footprint, rapid

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[37] David Beito, "Mound Bayou: Guns, Civil Rights, Free Speech and the Emmett Till Murder" (American Institute for Economic Research, 2023), https://www.aier.org/article/mound-bayou-guns-civil-rights-free-speech-and-the-emmett-till-murder/ (accessed March 10, 2024).
[38] De Jong, "Plantation Politics" (n. 24), 260–61.

hiring of staff, and an administrative board. Each of these milestones were the subject of competition between incumbent elites, OEO bureaucrats, and the clinic's directors, Geiger and Hatch. Each group sought to exert influence in favor their preferred model of community control, grounded in competing notions of community. The space for this competition was created, in part, by the absence of any strict definition of "community" or "maximum feasible participation" in EOA. To create a health center that was governed by the community it served, that community first had to be defined.

Yet community remained an unstable concept. Geiger and Hatch defined community by division, distinguishing between the "black ex-sharecroppers and ex-plantation workers who constituted the vast and silent majority of the black community" and Mound Bayou's middle-class town dwellers.[39] It was to the former that the Boston physicians felt maximally feasible oversight should be apportioned. The trouble was that middle-class townspeople immediately clashed with Geiger, Hatch, and Tufts over control of TDHC, for what were felt to be self-interested reasons, namely a desire to maintain control of the economic opportunities afforded by the town's existing, though limited, health care infrastructure. The dean of Tufts Medical School described this local opposition as originating from a "small, economically motivated and totally unrepresentative group in one community" that was distinct from "the great bulk of the black population from northern Bolivar County."[40]

[39] H. Jack Geiger, "The First Community Health Center in Mississippi: Communities Empowering Themselves," *Amer. J. Pub. Health* 106 (2016): 1738.
[40] Ward, *Out in the Rural* (n. 29), 149–50.

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These concerns drove organizers to request OEO's help in fending off middle-class interference. In late 1966, Hatch wrote to OEO requesting "consultative services" to guide the selection of locals to the clinic's nascent advisory boards that "include persons not affiliated with either fraternal order," including the locally influential Taborians.[41] Hatch feared that poor residents' administrative inexperience exposed their councils to undue elite influence. The fraternal orders were suspected of undermining TDHC to limit competition to the Mound Bayou Community Hospital (formerly Taborian), which they controlled. With the advent of Medicaid under the Johnson administration there was the possibility of a new, steady payor for health services in Mound Bayou, providing an opportunity for the Community Hospital to increase its revenues. The only question was which entity would receive the federal funds. To Geiger and Hatch, this middle class appeared more concerned with the preservation of their status and potential revenues over the amelioration of their neighbors' material needs.

In all their efforts, Geiger and Hatch consciously sought to avoid what Daniel Immerwahr has described as "community development's bias toward the rural elite"—the tendency for the benefits of such programs to accrue to existing landholders, business owners, and professionals in impoverished communities.[42] Regarding the failures of twentieth-century U.S. development efforts abroad, Immerwahr has written, "If one wishes to see poor people participate as organized communities, one cannot treat the notion of community sentimentally. . . . Where the community

[41] John Hatch to John Frankel, December 15, 1966, letter, UNC Wilson Special Collections, Jack Geiger Collection on the Delta Health Center, 1946–2016 (JGC), box 004, folder 101.
[42] Daniel Immerwahr, *Thinking Small: The United States and the Lure of Community Development* (Cambridge, Mass.: Harvard University Press, 2015), 93.

is, who is in it, and how it works are open—and often contested—questions."[43] This lesson proved valid closer to home. In their endeavor to limit elite influence, Geiger and Hatch demonstrated little awareness that their own romantic notions of "community" presupposed the existence of a discrete body of poor people who were neatly aligned with the social goals of two Boston physicians sponsored by the federal government.

For all of their emphasis on community control, the question of which community they served remained underexamined by Geiger and Hatch. Principally, Geiger and Hatch failed to recognize that members of the antagonistic middle class composed part of the Mound Bayou community the clinic was meant to serve or, at a minimum, a potential ally rather than opponent to their cause. There were limited early attempts at forging alliances with local leaders, as when Geiger met with Mound Bayou resident Earl Lucas. Lucas ran the local outpost of OEO's Systematic Training and Reeducation (STAR), an adult education program. When Lucas suggested that TDHC contract all staffing decisions to STAR, effectively placing Lucas in control of a vital source of community employment, Geiger responded that employment decisions existed within the remit of the town's poor residents.[44] While Lucas would go on to become a persistent foe of TDHC, not all members of the local middle class were engaged in such naked attempts to expand their political influence.

The middle-class town dwellers naturally did not see themselves as "totally unrepresentative" of Mound Bayou. Instead, they argued that they were the natural leaders of the area encompassing Mound Bayou and northern Bolivar County. To them, the local community

[43] Ibid., 178.
[44] Ward, *Out in the Rural* (n. 29), 140.

was indivisible, though with a clear hierarchy. In the town paper, the Mound Bayou *Voice*, local leaders couched their initial skepticism of TDHC in terms of noblesse oblige, identifying themselves as "prominent" and "substantial" citizens concerned that the health center might bring social upheaval to Bolivar County.[45] While Geiger characterized their skepticism, and at times outright opposition, toward TDHC as an attitude of "if we can't run it, we'll run it out"—it was more fair to characterize elite support as contingent upon the respect paid toward their self-perceived social station, rather than a fundamental antagonism to the idea of CHCs.[46]

OEO's notion of "community" fell somewhere between these poles. From Washington, it appeared that all of Mound Bayou deserved federal assistance, not just a subset of the poorest sharecroppers. To federal bureaucrats, it mattered little which locals served on clinic advisory committees, as they had no intention of granting the degree of community authority that Geiger and Hatch believed essential to make a successful health center. While OEO administrators could speak like activists, they acted as natural conservators of their own power, wary of devolving too much authority to uncontrollable grassroots groups. In a letter to OEO shortly after TDHC opened its doors, Geiger denounced the pressure from OEO to appoint a health center board at rapid pace incompatible with a genuinely representative selection process. "Under pressure from OEO for 'instant community organization,'" Geiger complained, the clinic would be forced to appoint a community board "representative of the existing elite in the community—the individuals and organizations that already have political interests or some power or status, not

[45] De Jong, "Plantation Politics" (n. 24), 268.
[46] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.

representative poor people."[47] To a large extent, this was fine with OEO. Token citizen involvement, regardless of the degree of community representativeness, fulfilled their bureaucratic conception of "maximum feasible participation."

Boston activists, local elites, and Washington administrators' competing notions of community—encompassing varying degrees of romanticism and self-interest—failed to involve their ostensible subject: the "great bulk of the black population from northern Bolivar County." In part this may have been a product of unformed class consciousness among the region's poorest citizens, a self-awareness that had yet to emerge prior to activists' organizing efforts taking effect. But poor residents' absence from the debate in their name also reflected a messier reality in which Mound Bayou's population did not tidily fit into predetermined social categories. While those locals directly in control of the Mound Bayou Community Hospital opposed TDHC as a competitive threat, other middle-class residents welcomed the center's new, much-needed facilities. Prior to TDHC, there was nonexistent government intervention in health care in rural Mississippi. Few physicians practiced outside of the state's urban centers, and in 1960 Mississippi's 77 physicians per 100,000 residents represented half the national average.[48] Even the relatively well-off in the town suffered from the extreme health disparities endemic to the Delta. While the "vast and silent majority" of "black ex-sharecroppers and ex-plantation workers" and the "economically motivated and totally unrepresentative" middle class that the activists identified were recognizable types in Mound Bayou, there was significant slippage between these groups in reality. There were elites who sought government assistance and poor

[47] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.
[48] De Jong, "Plantation Politics" (n. 24), 258.

people who resented outsiders' missionary overtures. The sharp distinctions drawn by activists did not entirely align with each group's self-conception. To the extent they sought a clearly defined, impoverished subpopulation in Mound Bayou to engage to a "maximally feasible" degree, Geiger and Hatch had to organize it into creation.

To achieve their preferred bottom-up model of community oversight, Geiger and Hatch set about organizing Bolivar County's poorest residents. After spending much of 1966 identifying a suitable clinic location, they set 1967 as the year when they would put the clinic on more stable operational footing. In his role as TDHC's director of community health action, John Hatch canvassed Bolivar County in early 1967, recruiting representatives for ten resident associations to provide community input for clinic operations. According to Geiger, they "literally knocked on the door of every house in northern Bolivar County inhabited by a black family."[49] Hatch sought representatives of the marginalized populations the clinic planned to serve—members who were illiterate, poor, female, disabled. The overall structure of these associations was based on that of the Southern Baptist Church in an attempt to mirror an organization with which local residents would be familiar.[50] The plan was for the resident associations to elect members of the North Bolivar County Health Council, TDHC's main organ for community oversight. According to Hatch, the resident associations obtained "broad based

[49] Ibid., 265.
[50] John Hatch, "Community Development in a Rural Comprehensive Community Health Program" (presentation, New York Academy of Medicine Annual Health Conference, April 24, 1970), transcript, JGC (n. 41), box 001, folder 4.

community support," eventually securing the participation of more than two thousand locals from the surrounding region.[51]

In these early years, TDHC's leaders had operated with significant autonomy under OEO's protection. However, in 1967 operating conditions grew more contested with Congress's passage of the Quie and Green Amendments to EOA. The amendments delegated a portion of OEO's discretionary oversight of federal funds to local institutions across the country. Powerful incumbents—mayors, governors, political bosses—could decide which projects could receive federal dollars, and which to starve of resources. Federal funding for more radical grassroots groups, such as TDHC, was threatened by a newly emboldened local power structure. And as the local conflict for resources intensified, it exacerbated preexisting community tensions, often between and within racial groups. "As local governments played favorites with desperately needed funds," Annelise Orleck argues, "intraracial conflicts flared up in many communities. In Deep South states, competition for control of federal antipoverty dollars exacerbated long-existing tensions between poor black farm workers and more educated and affluent Black town dwellers, who saw themselves as the natural leaders and representatives of their race."[52]

For Geiger and other white activists, emphasizing the intraracial dimensions of local conflict—perhaps inevitable in a racially homogenous community—enabled a blindness to the racial dynamics of their own position. To be sure, there were very real tensions between Black townspeople, which Greta de Jong has examined extensively during this era. She quotes a 1968 legal complaint, sent on behalf of a "prominent citizen" who claimed to speak for Mound

[51] De Jong, "Plantation Politics" (n. 24), 265.
[52] Orleck, "Introduction" (n. 4), 14.

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Bayou's "more substantial people," expressing concern that TDHC was creating "untold dissension" in Mound Bayou by paying above-market wages.[53] This attitude was not unique, and local elites would go on to enlist everyone from Washington consultants to the national press in their attempt to influence TDHC's direction. Yet racial mistrust also took on a more traditional, Black-white dynamic, providing a window into local skepticism toward many of the Tufts team's attempts to organize Mound Bayou's population. One editorial, in the elite-controlled Mound Bayou *Voice*, credibly asserted that white entities, Geiger and Tufts, held all meaningful power at TDHC, and that Geiger's influence over poor locals amounted to little more than a recapitulation of Jim Crow white supremacy. "Blacks do not need whites to think for blacks . . . NO white can be allowed to choose the black leader any more."[54] To Geiger and his allies, these criticisms represented an easily dismissed attempt by local elites to hold on to their relative socioeconomic position over fellow Black citizens. Geiger, especially, scorned any racial explanation that might explain opposition to the clinic, favoring instead a class-based analysis in which the "Negro middle class . . . has been helping to oppress the poor rural Negro and preserve its own privileges."[55] Geiger seemed to ignore the possibility that locals' opposition to TDHC could stem from skepticism of a white outsider representing a white university.

Middle-class opposition placed TDHC's organizers in a bind. They believed in the possibilities of community control, yet here was a sizeable portion of the community that held alternate expectations for how to enact such control. How democratic was a model of clinic

[53] De Jong, "Plantation Politics" (n. 24), 268.
[54] Ibid., 269.
[55] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.

governance that viewed a significant share of the local population—ostensibly members of the community the clinic was intended to serve—as oppositional figures to be omitted from clinic oversight? Were activists dealing with Mound Bayou's population as a real and complicated entity, albeit one that possessed dissenting competitive factions, or were they preoccupied with a romantic notion of an impoverished community that was dependent on external assistance? To deepen the difficulty of their situation, the more activists sought intervention from OEO, the more they undermined the viability of local control. How sustainable was a form of local control that relied on federal support that could, at any moment, weaken or disappear?

With these questions unresolved, Geiger, Hatch, and their allies entered 1968. Clinic services had started in late 1967, operating from the parsonage of the Lampton Street Church. By 1968, the clinic was on the lookout for more permanent facilities. Throughout the early months of 1968, Geiger was a frequent correspondent of Dr. John Frankel, his main contact at OEO, whom he lobbied to shift control of TDHC to a representative body of community members. Frankel preferred to distribute money to the Mound Bayou Development Corporation, a Tufts-controlled trust subject to direct OEO influence. To Geiger, the construction of the clinic—involving large local expenditures and new jobs—was exactly the kind of project that should be supervised by the community itself, embodied in a democratically selected council. "[The] issue," Geiger wrote to Frankel, "is the question of community involvement and representation. . . . I would expect that representatives of the Board of Directors of this community organization would have to be by open election from all of Northern Bolivar County."[56] Frankel affirmed that "securing community participation . . . is a priority matter" and

[56] Jack Geiger to John Frankel, February 15, 1968, letter, JGC (n. 41), box 001, folder 4.

promised that a yet-to-be-formed "community health council will have a substantial policy voice in the operation of the center."[57]

Deriding Frankel's favored Development Corporation as a "'colonial' trust . . . lacking in local representation," Geiger took the step of replying with a personal letter—addressed to Frankel's home rather than OEO headquarters—forcefully outlining his worries.[58] The bulk of the eight-page missive contains what Geiger called his "natural history of community participation and the relationship between health centers and community organizations."[59] The letter provides Geiger's unfiltered analysis of the struggle for CHC governance. It is his most detailed articulation of the role and definition of "community" in a health care setting and his vision for the "maximum feasible participation" of locals in TDHC's operations. It is also, somewhat contradictorily, both a plea for increased OEO assistance and a polemic against federal interference in grassroots organizing.

Geiger presented his "natural history" in four phases over the lifespan of a health center. In the first of these phases, Geiger argued that institutional sponsors such as OEO attempted to dominate community voices out of a paternalistic sense of primacy in community matters. In Geiger's telling, entities such as the Mound Bayou Development Corporation were "usually linked in with a number of romantic notions about the mystique of the poor, the ease with which they can organize themselves and the contributions they can make right from the start." There was an assumption that poor residents lacked an ability, at least initially, to meaningfully

[57] John Frankel to Jack Geiger, March 6, 1968, letter, JGC (n. 41), box 001, folder 4.
[58] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.
[59] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.

participate in efforts to transform their material conditions. Geiger believed that well-intentioned, top-down efforts could not be socially transformative without empowering marginalized voices within the community—a more lengthy and fraught process than either Tufts or OEO was prepared to undertake. "Underneath all this," Geiger argued, what an institutional sponsor "usually really wants is a passive, grateful window-dressing advisory committee without any real control—and that is exactly what it usually strives to create." Despite these tensions, Geiger noted, "During this phase, everyone is happy: the university with its benevolent paternalism, the-not-very-representative community organization with its status, and OEO with all the harmony it has wrought." Throughout, Geiger returned to the idea that TDHC needed to jealously guard impoverished locals against a "window dressing" model of clinic governance that upheld the status quo of community relations and power.

In Geiger's "natural history," the relationships between health centers, community members, and institutional sponsors do not persist for long in the initial state of benevolent paternalism. In the second phase, the involved groups move into open confrontation, with each group competing for a greater share of control. This phase begins with the compliant elites selected for the community board realizing they lack any real power. "It takes somewhere between two months and a year for the community organization to decide it has been cheated and to become both militant and effective about the militance—i.e., learning how to make specific demands of the health center, seeking other support, or going to OEO itself." Then, in response, "the university or the project directors and the health center staff now find themselves becoming very angry and for the first time have to recognize and confront their own paternalism." At stake, to Geiger, was a conflict between two "fantasies": the elite-dominated community board's

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"fantasy . . . that it will have real control over jobs and budget" and the "university's fantasy that it can have community organization without giving up any real power to a nice passive community group." Geiger returned repeatedly to his fear that the most marginalized patient voices would be involved only as tokens, far below a "maximally feasible" threshold. "I fear that unrealistic attitudes and pressures for rapid community organization, continuing harmony and the mystique of the poor, will result in much less community control than could otherwise be accomplished."

Structured as the inexorable progression of "natural" forces, Geiger's analysis presented his favored conclusion as a fait accompli. The "natural history" culminates when appropriate authority is delegated to a board with genuine representation of marginalized voices. To oversee TDHC, Geiger favored the establishment of a "new non-profit organization with four board members elected by the community, four appointed by [Tufts], and two others acceptable to both groups," with specific emphasis that any health care providers—up to this point, nearly all had been directly employed by Tufts—serve "under this organization." While up to this point the "maximally feasible" degree of community involvement had been undefined, here Geiger gave it a number: four slots out of ten on the board of a proposed nonprofit. This structural solution accommodated the dual need for community input and professional expertise, while acknowledging, through the suggestion that two board members be "acceptable to both groups," that these forces might occasionally conflict. Thus, Geiger understood that TDHC's administration needed to oblige both consensus and dissent, though only within acceptable bounds. There was no place in this model for the local middle class to participate in TDHC's governance.

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For all the inexorability toward his favored outcome that the "natural history" presupposed, Geiger remained concerned that elite interference could, at any moment, derail the TDHC experiment. A year after his letter to Frankel, fearing that TDHC's opponents had infiltrated the health center's nascent advisory committees, Geiger returned repeatedly to the threat posed by local elites who might superficially resemble the most marginalized voices in the community but whose intentions were at odds with the goal of bottom-up empowerment. Geiger illuminated this perspective in a letter from March 6, 1969, to civil rights activist Howard W. Hallman:

> The blacks on the staff and advisory committees . . . are carefully selected toms and I am skeptical that there is any meaningful representation whatsoever of the impoverished Black community . . . the existing black middle-class conservative power structure tends to be put to use by the dominant white power structure for purposes such as this. Thereby serving the needs of both: The whites to maintain control, and the middle-class blacks to maintain their relative status, power, control of the action and possible exploitation of others (the rural poor) within the black community.[60]

In addition to assailing the role of entrenched elite interests, Geiger also remarked on the threat of "black power militants within our own staff and outside it; these persons automatically defined themselves as 'the community' or 'the voice of the community'" but who were not, in Geiger's estimation, truly representative.[61] Moreover, these "militants" were often unreceptive to any assistance from Geiger, Hatch, and Tufts—agents of outsider, white-coded power, even if Hatch was himself Black. Indeed, Hatch echoed Geiger's characterization of their critics,

[60] Jack Geiger to Howard W. Hallman, March 6, 1969, letter, JGC (n. 41), box 001, folder 4.
[61] Jack Geiger to John Frankel, March 28, 1968, letter, JGC (n. 41), box 001, folder 4.

observing that "black militants questioned the appropriateness of a 'white' institution proposing to provide services in a predominately black community."[62]

Geiger's dismissal of Black opponents as "toms" deserves attention for what it reveals about Geiger's self-conceived relationship to Blackness and its authentic expression. At the time of Geiger's letter, the term was understood as a slur against an African American perceived as overly subservient to white society, who "sacrifices his race for his own interests."[63] Unlike most other racial epithets, the derogatory nature of "Uncle Tom" stemmed from its intraracial use, a means for African Americans to brand one another as inauthentically Black or overly submissive to white society. Geiger's use of the term assumed a personal understanding of Blackness and, in a reversal of the term's typical directionality, smeared those who dissented from his implicitly white worldview, rather than compliantly accept it.

Taken together, local opposition to Geiger and Hatch's plans for TDHC, from both middle-class "toms" and "Black power militants," amounts to a more complicated picture of social relations than Geiger presents in his "natural history." One is struck that Geiger and Hatch dismiss any Black voice that does not represent their views of what is best for the poor Black community defined on their terms. Moreover, the poor community for which they advocate is defined only in opposition to a group—also locals, also Black—with competing claims and interests. To the out-of-state physicians, local "community" was composed of Black residents who desired social change—but were not too radical—and who approved of TDHC's plans for

[62] Hatch, "Community Development in a Rural Comprehensive Community Health Program" (n. 50).
[63] Adena Spingarn, *Uncle Tom: From Martyr to Traitor* (Stanford, Calif.: Stanford University Press, 2018), i–xii.

development—but were not overly compliant "toms." This model made little allowance for a heterogeneity of Black perspectives and motivations. In essence both Geiger and Hatch fell for the same "mystique of the poor" that Geiger so vociferously criticized. Undoubtedly there were interests in Mound Bayou opposed to the grassroots transformation promised by TDHC. Nonetheless, by positioning themselves as defenders of the working poor while delegitimizing local opposition, Geiger and Hatch betray an attitude that smacks of the paternalism that "maximum feasible participation" was intended to obviate.

What, ultimately, were the consequences of this attitude for the people of Mound Bayou? In 1968 and 1969, success followed hard-won success for TDHC. For all the factional conflict that appeared to threaten the TDHC before it could come into existence, its founders were able to acquire a permanent space in 1968. The clinic saw an immediate influx of patients—more than eight thousand in its first year—and began offering apprenticeships, home health services, Head Start programming, and more.[64] That same year, a five-hundred-acre farm collective was established, bringing a much-needed source of food and employment to Bolivar County. "The land was here; the people were here; and the hunger was here," was how the collective's founding director, L. C. Dorsey, described the community's need for agricultural reform.[65] And, in realization of Geiger's plan for formalized community representation in clinic operations, the North Bolivar County Health Council—set up by Hatch over the course of 1966—was granted five seats on TDHC's board of directors. That same year, OEO began to issue grants directly to the Health Council, rather than remit them through Tufts as an intermediary.

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[64] Ward, *Out in the Rural* (n. 29), 156–70.
[65] Ibid., 111.

However, preexisting community tensions remained, endangering TDHC's survival at the turn of the decade. The largely economic roots of the conflict over TDHC's future were only heightened by its successes. Middle-class townspeople continued their attacks on Geiger in the Mound Bayou *Voice*, assailing him as "the boss man."[66] By 1970, Earl Lucas, then mayor, threatened to tax TDHC (a tax-exempt facility) and extort it for a new municipal fire engine and garbage truck. By way of leverage, he suggested the town was considering the installation of a sewage lagoon beside TDHC.[67] Yet local antipathy to Geiger and TDHC was not merely driven by economic interest and petty power politics. Locals in control of Mound Bayou's preexisting community hospitals did not require an economic rationale to feel condescended to when Geiger, in a 1969 interview with *Life*, said of TDHC, "I guess we were practicing missionary medicine. . . . We [created] a comprehensive health program where virtually none existed."[68]

In 1970, Geiger resigned as director, accepting a role as head of the Department of Community Health and Social Medicine at the State University of New York, Stony Brook. He had never intended to say in Mississippi and since 1968 had been searching for a replacement. His departure was simultaneously a gesture of vulnerability, as an acknowledgment of his polarizing status in the community, and one of strength, as the health center could operate without his constant intervention. His replacement, L. C. Dorsey, was selected both for her prior work on the farm collective and as emollient to those who had opposed Geiger on the basis of his

[66] Ibid., 146.
[67] Ibid., 140.
[68] Richard Hall, "A Stir of Hope in Mound Bayou," *Life*, March 28, 1969, 72.

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outsider status. Born to a sharecropping family in nearby Tribbett, Dorsey could not be accused by local elites—as Geiger had been, however unfairly—of reincarnating a plantation taskmaster.

By the time of Geiger's departure in 1970, the question arose whether Tufts would continue as sponsor. In August of that year, the dean of Tufts Medical School wrote a letter to OEO—eventually leaked to the Mound Bayou *Voice*—that criticized the quality of medical care at Mound Bayou Community Hospital and echoed Geiger's prior rejection of a racial explanation for local opposition to TDHC:

> We have often felt that O.E.O. was responding to the view that these were problems of an "outside" "white" institution being rejected by a black population that it served, or that O.E.O. was responding to charges that it was unfairly discriminating against a black institution, the [Mound Bayou Community] hospital, and therefore trying to treat the two institutions as identical in both strengths and functions. In our opinion, the view that an outside white institution was being rejected is simply not true.[69]

Many at Tufts were increasingly fatigued by the controversy attending its sponsorship. And with the departure of Geiger, TDHC had lost its most vital ally at the university. Tufts and the Health Council both agreed it was an appropriate time to find a new health center sponsor. In 1970 the Health Council conducted visits to universities and hospitals across the United States in search of backers, but eventually settled on the one with which they were most familiar: Geiger, now at Stony Brook. Unsurprisingly, Geiger's rivals resisted the Stony Brook alliance. The always oppositional *Voice* claimed, "The chief reason for deciding to affiliate with Stony Brook was that the boss, Dr. H. Jack Geiger, went there and he wanted to change the Center's affiliation to Stony Brook."[70] The greater the power poor residents exercised over the health center, the more opponents asserted that they were marionettes in the hands of a white master. Despite the

[69] Ward, *Out in the Rural* (n. 29), 149–50.
[70] Ibid., 152.

renewed opposition, it initially appeared that the Health Council's faith in Geiger would pay off. Under Stony Brook's patronage, the citizen-led Health Council was given control of essentially all operations at the rechristened Delta Health Center. By the end of 1971, it appeared that a significant step toward "maximum feasible participation"—however vaguely defined—had been achieved.

However, at the very moment that strides were made toward "maximum feasible participation" at the Delta Health Center, it was being unwound in Washington, D.C. Mayor Lucas lobbied President Nixon's OEO to merge the Delta Health Center and Mound Bayou Community Hospital, arguing that they offered redundant services and that the mayor should be given control of the consolidated organization.[71] OEO readily agreed. As Greta de Jong has written, "Restoring control to Mound Bayou's administrators was politically appealing [to Nixon] because it allowed the president to make points with the advocates for greater autonomy even as he appeased conservative southern supporters who expected action on election promises to roll back Federal interference in their states."[72] In January 1972, OEO ordered the merger—stripping the health center of its Stony Brook affiliation—while also expanding the new institution's services to three neighboring counties.[73] This expansion-cum-merger overextended the entity's already strained resources, while consolidating oversight within the Mound Bayou establishment. The overall effect was to simultaneously place the new entity on weak financial footing while ushering in an administration drawn from Mound Bayou's middle class.

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[71] Ibid., 150–54.
[72] De Jong, "Plantation Politics" (n. 24), 271–72.
[73] Ibid., 273–74.

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Thus, the expanded Delta Community Hospital and Health Center came into existence enfeebled by federal indifference and a challenging local political environment. All of TDHC's original leaders had moved on and much of its grassroots energy had faded. The new board was controlled by Mayor Lucas, who had secured his goal of takeover-by-consolidation. By 1972 the national atmosphere was markedly less hospitable to antipoverty policy experimentation than it had been during the Johnson years. Moreover, the organization lacked any university sponsor—such as Tufts or Stony Brook—that might act as a political ally, financial backer, or source of medical staff.

While the merged entity never ceased operations in the years to come, it struggled to maintain financially viability. By 1977, a National Committee to Save Mound Bayou Community Hospital was formed to raise money and awareness. The committee included unexpected bedfellows Earl Lucas and Jack Geiger alongside a diverse list of luminaries: Harry Belafonte, Shirley Chisholm, and Sargent Shriver, among others. The committee issued a fundraising appeal outlining a brief history of the hospital, noting its status as a "symbol of black pride and achievement—the only black controlled hospital in the State."[74] The leaflet depicted the Community Hospital and Delta Health Center as "sister component[s]" with a shared mission: "[the Health Center] could not survive for long if the hospital closed. The [Hospital] is the only facility to with the Health Center car refer its out patients . . . for further medical care or hospitalization." In this telling, the histories of each "sister component" became entwined, any

[74] National Committee to Save Mound Bayou Community Hospital, "A Call to Americans to Save the Hospital at Mound Bayou," March 16, 1977, letter, SWHA, HH, miscellaneous materials.

conflict smoothed over, with past rivals Lucas and Geiger united, however briefly, toward a shared goal.

By 1977, Mound Bayou had spent ten years experimenting in community-controlled health care. Though the town and surrounding Bolivar County were, from an outsider's view, seemingly homogenous in their demographic makeup, this experiment was characterized by continuous conflict, never more so than over the unstable definition of the community that was supposed to administrate TDHC. That a grassroots-focused health center existed at all was a testament to the efforts of its leaders and the political contingencies of the War on Poverty. Its existence was also testament to the dire need, in Bolivar County, for a clinic that served all residents.

There is no doubt that any grassroots experiment in health delivery to a Black community in 1960s Mississippi would have faced hostility from establishment figures at the state level. By contrast, opposition from local Black leaders was not a fait accompli. By treating Black elites' distrust of TDHC as illegitimate, Geiger, Hatch, and colleagues isolated potential influential allies. Moreover, by delegitimizing critics as inauthentic tools of white authority, they failed to recognize the diversity of viewpoints in Mound Bayou and its environs. Tufts physicians' approach to community health care was simultaneously defined by a genuine desire to catalyze grassroots action and a patronizing attitude toward any locals who deviated from this plan. This approach destabilized local support for TDHC and made its intended project more difficult to achieve. The conflict of its early years required TDHC's advocates to intervene repeatedly on behalf of the clinic's survival. TDHC relied on external support to fight local opposition, and when its powerful supporters moved on to new jobs (or when presidential administrations

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changed), support evaporated. Geiger and Hatch were unable to create the self-sustaining architecture of local control that comprised the health care delivery model TDHC was meant to accomplish. By sidestepping the deliberative processes that could have led to compromise and buy-in from skeptical elites, the existence of the center—in its most radical form—was conditioned on inconsistent external support. Ultimately, Geiger and Hatch's mystified conception of Mound Bayou's community undermined the "maximum feasible participation" for which they fought.

Conclusion

Community health centers began as an effort to meld social liberation, community development, and health care delivery. Continuing a trajectory initiated by early twentieth-century reformers and labor advocates, health center advocates iterated upon the concept of patient authority in health care. Rather than the means of production, activists sought the emancipatory potential of controlling the means of health provision. During the War on Poverty, CHCs extended this concept to ambitious new heights that, perhaps inevitably, were stymied by both entrenched interests and activists' strategic missteps.

Viewed broadly, the story of TDHC illustrates both the promise and the fragility of government-backed grassroots action. Reliance on federal support created a paradox: grassroots empowerment required external resources, yet outside intervention—from the government, from well-intentioned activists—inflamed local tensions and fostered dependence on institutions that could not sustain long-term investment. Through such structural limitations, government-backed

grassroots experiments risk becoming noble yet ephemeral experiments in social transformation, undone by the power structures they seek to transcend.

At Mound Bayou, it was likely always overambitious to contend that CHCs could, through consumer oversight of health delivery, rapidly alter the fate of a community steeped in centuries of racism, poverty, and neglect. Indeed, in an editorial from 1993, twenty-five years after TDHC opened its doors, Geiger admitted that health centers were "idealistically" and "grandiosely" conceived as instruments of social change.[75] As a result of this idealism, perhaps, TDHC's founders misjudged the political terrain of Bolivar County. The health center was welcomed by poor families who might benefit from its services. At the same time, it was greeted distrustfully by a middle class that feared disruption to their way of life. Regardless of their respective attitudes toward TDHC, both groups fell within the remit of its mission—the racialized poverty of the Jim Crow South and the region's pressing health needs fell on all residents' shoulders, if unevenly. To the extent that locals welcomed TDHC, its founders accepted them as the clinic's rightful patients and future leaders; to the extent that locals expressed skepticism or opposition, they were dismissed as self-dealing "toms." Of course, not all locals could be brought aboard, and any project contingent on an unanimity of local opinion is doomed to futility. Nonetheless, a genuinely citizen-controlled model of health care delivery required engagement with the untidy conciliations that citizenship requires: disagreement, negotiation, compromise. In delegitimizing and disregarding local opposition, TDHC's founders inflamed preexisting tensions that set the health center on a course for future instability. Assuming that the center belonged solely to the community members naturally aligned with their

[75] Geiger, "Community-Oriented Primary Care" (n. 18), 947.

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plans, TDHC's founders introduced structural vulnerabilities that undermined the social transformation "maximum feasible participation" was intended to achieve.

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