

CAMBRIDGE

June - July, 1971 * 50 cents

On patrol with the Cambridge Police



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June -- July, 1971

Vol. 1, No. 6

Publisher

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this issue:

pg.	2	Inside
pg.	4	Review
pg.	6	Affairs
pg.	12	Profile
pg.	15	Cambridge Hospital: Treating What Really Hurts
pg.	20	On Patrol With The Cambridge Police
pg.	24	Avant-Garde On Garden Street
pg.	27	The Scene
pg.	32	Column

SUBSCRIPTIONS, ADVERTISING INFORMATION: 876-4100

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CAMBRIDGE is published bi-monthly by the Cambridge, Massachusetts Chamber of Commerce, 69 Rogers Street, Cambridge, Massachusetts 02142. Malcolm F. Fryer, Jr., Executive Vice President. Entered as third class mail at the post office, Cambridge, Mass. Advertising rates upon request. Subscription rate is \$2.00 per year - 50 cents per copy. Copyright 1971 by the Cambridge Chamber of Commerce. No part of this magazine may be reproduced or reprinted without express permission of publisher. The Chamber of Commerce does not assume responsibility for opinions or facts stated by authors. Unsolicited manuscripts must be accompanied by return envelope and postage.

CAMBRIDGE-2

Among this city's many distinctions is its crime rate - higher than any other U.S. municipality its size. Starting on page 22, the Cambridge police talk about some of the problems of policing the city, and the work going on to better current police-community relations.

One of the higher crime rate categories is burglary. If you own a business in the city, and want to reduce your vulnerability to theft, you might want to consider the following suggestions made by some members of the department:

1. Keep your premises well lighted at night; burglars know the risks of high visibility.

2. When you leave at night, leave your cash register open. An intruder may not know it is empty; and smashed, it is worth nothing to you either.

3. If you've been having trouble with breaks, call the police station and get someone over to check your property for security problems and easy access areas. They know what to look for, and can perhaps advise you on precautions to take.

4. Lock and *double* lock your doors. Locks may not be impenetrable, but they slow a burglar down. (And if he is standing in floodlight, he may decide it's not worth the risk).

5. Finally, have an up-to-date file at the police station, giving the name of who to call in the event of an after-hours emergency.

Nothing is fool-proof, but these precautions can make a difference.

Public health problems in Cambridge, as in many urban areas, no longer just center around infectious diseases. Instead, they increasingly include health problems stemming from social and psychological complications of modern life. Cambridge Hospital, in the past five years, has undergone significant change, and is emerging as a community health center, increasingly prepared to deal with these problems. The story of the program, *Cambridge Hospital: Treating What Really Hurts*, begins on page 15.

Your comments on *CAMBRIDGE* are always welcome. Let us hear from you.

B.J.M.

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Cambridge Hospital: Treating What Really Hurts

Take a city like Cambridge where there are only six general practitioners and, reportedly, only one makes house calls and you don't know him anyhow, and it's the middle of the night and you're sick. It could be just too bad. Technically, the time could be 12 noon for that matter because most doctors are booked solid and if one let you in day-after-tomorrow you could be dead by then, right? So you drag yourself, embarrassed, to an emergency room where you envision sitting among the heart attacks and brain tumors to find out, no, your cold is no more than bronchial pneumonia.

In the past ten years, the medical problems of city people have increasingly centered upon: Where do I go when I'm sick? If you're poor, you find very few, if any, new doctors flocking to your neighborhood; with the high costs of medical training, new doctors, laden with bills upon graduation, escape to suburbia -- away from Medicaid and its sometimes-get-paid, sometimes-not problems. (There are no new doctors east of Harvard Square). If you're young or old or new to a community, again, who do you go to for help? Tuberculosis and other infectious diseases are coming under control, but

who treats the other massive, modern medical problems: alcoholism, drug addiction, degenerative diseases of the aged, child neglect, mental illness -- the social problems. "These are killing us," says a Harvard public health specialist, and only recently have we begun to take them out of the closet to face with any intelligence.

Ten years ago, when Cambridge Hospital was still Cambridge City Hospital, NBC and a young-looking Chet Huntley did a "White Paper" profile on the place, a "typical" city hospital with city hospital problems. Too few beds, dingy quar-

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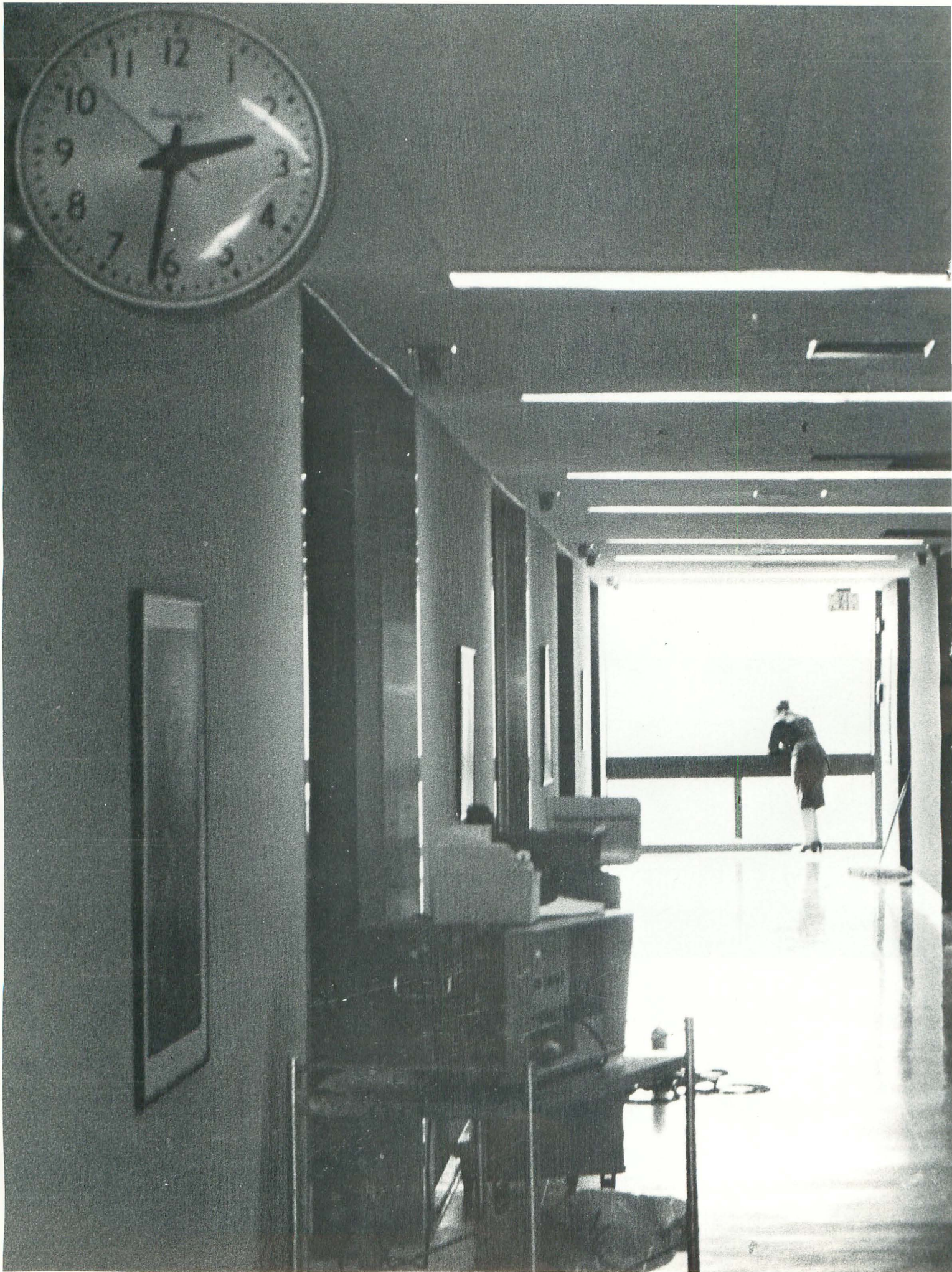


Photo: Bernadine McLeod



Hospital – continued from page 15.

ters, foreign interns creating training gaps and language problems;* inadequate facilities, were all part of the problem -- highlighted in the film that I watched one recent Friday afternoon in the second floor laboratories of the new hospital, with a pack of nurses-in-training and interns (the latter a product of a recent, much cherished affiliation with Harvard Medical School). "Office workers miss the old place," said a secretary; "we knew everyone then." But with the new structure, built in 1965, has come the start of a new focus and new treatment of what's really hurting us in Cambridge these days.

Dr. Anthony Scapicchio, a general surgeon, and the new head of the Cambridge Hospital emergency suite says that in the past five to ten years, emergency room visits have increased almost 200%. If the new businessman in town, the low-income family, the student gets sick, where do they go for immediate care? "In a stable, rural population," says Scapicchio, "there's the family doctor; here the population changes yearly, and people have few, if any, medical ties." As it ends up, maybe 20-25% of the visits to the emergency room are "true" emergencies, but the importance of this fact diminishes in light of new, broad concepts of what an emergency room is. "Some people may have a minor emotional problem and need someone to talk to; some may have extreme discomfort with a minor but needed-to-be-treated illness," said Scapicchio. "Once hospitals were for the dying and emergency rooms for the injured. To some extent they still are, but today, no one here is going to snicker if your illness is an emergency to you. No one gets turned away."

Dr. Scapicchio works a 40-hour week and plans are to hire three other physicians to provide 24-hour supervision for the nurses, orderlies, corpsmen, and interns who man the emergency service. Perhaps the only group he may be seeing less of these days is children, especially from the lower socioeconomic neighborhoods in town, who used to flood the emergency ward up to two years ago. Unfortunately, that was a problem, but not so much a problem as the numbers of children who *never came*. "Poor quality child care is as evident in Cambridge as it is in other urban areas in the country," says Mrs. Ruth Cowin, a public health social worker and head of the social services department at Cambridge Hospital. So two years ago, a program was designed to reach children, some who might have entered school without any prior medical care, via a system of five satellite neighborhood clinics in

(Continued on next page)

* "A patient came in complaining about a pain in tummy," recalled a young, foreign doctor, interviewed for the "White Paper" report. "It took me a long while to figure out just *who* tummy was."

areas of high pediatric population -- Model Cities, Roosevelt Towers, Jefferson Park. "You can't get doctors in low-income areas," says Dr. James B. Hartgering, commissioner of health and hospitals in Cambridge. "In fact, the doctor shortage is everywhere; half the newly-licensed physicians in the United States are graduates of foreign medical schools." As a result, the hospital has turned to a new health professional, the nurse practitioner, specially trained and offering the health maintenance care that the over-worked and "crisis-oriented" physician has no time to handle.

When she first chose nurses for the nurse practitioners training program, Mrs. Margaret Murphy, for thirty years a nurse at the hospital and now head of the nurse practitioner program, was looking for women who wanted to be "more than a robot, a third hand to a physician." It's the nurse, says Mrs. Murphy, who has traditionally given primary health care in many parts of the world; in Cambridge, under the supervision of the hospital's chief of medicine, she is now doing immunizations, total examinations (checking for undetected health problems), while turning acute care cases over to a physician. "We worried that people in the community would object to being cared for by nurses," said Mrs. Murphy. This has not been the case. And, significantly, last year the nurse practitioners at 109 Windsor Street, the first pediatric center, knew every single child in the area entering the first grade -- 30-40% of which, without their work, would never have had health care at all.

The federal government provides substantial funds for child-care programs, but only recently has any funding come through for care of the elderly -- a huge population in Cambridge. This age group presents very special medical problems; often, they have multiple, chronic diseases requiring the long-term maintenance not readily available from the crisis-oriented doctor. They can, too, be frustrating to treat. "Elderly people often expect you to have magical diagnostic powers," said Mrs. Murphy. "'How do you feel?' you ask a patient. 'Fine.' 'Your ankle looks swollen.' 'Yes.' 'How long has it been swollen?' 'Past few days.'" The patients often don't see the importance of co-operating, of describing their symptoms. The elderly, too, often think that they are supposed to feel sick, or be out of breath, or they are supposed to cough. "They need health care," said Mrs. Murphy, "and they need education."

At the moment, six nurses are undergoing the four-month practitioner training program in preparation for the summer opening of new satellite clinics for the elderly in North and West Cambridge (where the elderly of the city have been moving from the housing problems of

East Cambridge and Cambridgeport). The nurses are trained to interpret an electrocardiogram, do lab tests, use a stethoscope, do dental assessments, eye exams, and diabetic tests, check for signs of serious diseases, and keep an eye out for malnutrition. "People are living longer today," said Mrs. Cowin, "and, as such, the degenerative diseases of the elderly are one of our most serious modern public health problems."

Another is meeting the psycho-social needs of the sick which prompted the enlargement of the Cambridge Hospital social services department last fall (to a staff of 13), under the direction of Mrs. Cowin, a fellow of the American Public Health Association. Each week, the staff reviews records on all patients admitted to the hospital -- in search of psychological and social problems causing or complicating an illness. Social workers consult to physicians, to the psychiatric department, and contribute to the program planning of the hospital. Among the high priority patients (seen in group and individual sessions with social workers) are unmarried mothers or young mothers in the psychiatric service. "We have a girl with a 62 I.Q. who is going to deliver in two months," said Mrs. Cowin. "We are already working to make provisions for the baby." Others include children with school problems, disabled patients now in need of new job training and encouragement, men, unable to cope with high-pressure jobs who are continually sick -- the list is endless. (The Monday morning I spoke to Mrs. Cowin, an elderly man whom I had seen many times before in Cambridge, waited in her outer office while she called to make arrangements for him to shower).

"One of the most crucial problems in this community," said Mrs. Cowin, "is the large numbers of children who are not necessarily 'abused' per se, but whose care is so poor that it is plain neglect. And there is no law to cover this. Much of Cambridge housing is poor, and often we come across cases of lead poisoning where children, left alone, eat the sweet lead-base paint, still on the walls in many of these places." Outright child abuse is much easier to spot, says Mrs. Cowin. If a physician even suspects that an injury is man-made, it must be reported to the social service and the Division of Child Guardianship.

The social service and psychiatric departments at Cambridge Hospital are highly interrelated due to a key question in most mental illness: How did the patient's family background contribute to his illness? Can his family be part of the treatment? Two and a half years ago, before the psychiatric unit opened up at the hospital (as part of the Cambridge-Somerville comprehensive mental health and retardation program), most patients who could not afford private psychiatric help either lived with their illness or had

to go out of the city for treatment. Today, on the fourth floor of the Cahill House, adjoining the new hospital building, a psychiatric ward serves 22 resident patients and 1,000 out-patients per month with short-term psychiatric care designed to emphasize a rapid return to community life.

"We know today that the mentally ill should not be isolated," said Mrs. Cowin. "Years ago we built beautiful institutions way out in the country where patients were put like pariahs. By hospitalizing a patient in a general hospital, the illness is put in perspective, treated like any other medical problem." For an individual having his first bout with mental illness, no one need ever know. And if he has a home situation that the psychiatric department deems "trustworthy," his return would be rapid, with follow-up care carried out via group and individual sessions with any of the department's 60 mental health workers.

"We hospitalize more young people than old," said Dr. James Beck, chief of community service, in the department of psychiatry, "because more of the serious mental illnesses -- schizophrenia, for example -- hit young people." The average stay on the ward, an area filled with magazines, folding chairs, handmade decorations with rooms set aside for sleeping and recreational activities, is 24 days, and all patients are there on a voluntary commitment. Patients are referred from the emergency unit, for which the department is on 24 hour call; by social workers; or someone will call up and say, "I'm worried about my son. He was in West-boro and he's starting to act crazy like he does just before he has to go in again." "We offer no magic treatment," said Dr. John E. Mack, chief of psychiatry, "we just have bright, sensitive, caring people. The reality of mental illness is that if the patient has an environment which promotes mental health, and can have visitors, and his family is prepared to work with him appropriately, then even acute problems can be worked out to be treated on a day-care and out-patient basis."

Ruth Balsler is one of 20 "mental health technicians" or attendants, as she calls herself, who work on the wards with the patients. A graduate of the University of Rochester with a B.S. in psychology, Miss Balsler received almost all her training at the hospital -- observing on the ward, and attending both teaching conferences and weekly supervisory meetings. Attendants often work with confused people and try to keep them oriented, talk informally with patients to find out how they feel and where they ran into trouble, encourage the formation of groups, and help the patients keep in touch with reality. Miss Balsler leads a social hour for depressed women, plays ping-pong with patients, and is available on call to the emergency room to talk initially with patients who

(Continued on page 28)



Hospital – continued from page 18.

may have a drinking problem, or who are upset and confused. "The hospital believes a great deal in the role of the non-professional," she said.

Drinking problems in Cambridge affect perhaps one out of seven people, but for years, in the city as in the country at large, the problem has been generally ignored by the medical profession. "Doctors have not been interested in alcoholism," said Dr. William Clark, director of a new treatment program at Cambridge Hospital which will expand this summer to include a 10-bed in-patient facility. "Alcoholics have traditionally been stigmatized, 'judged' by society. Yet, alcoholism is a major problem and one of the most preventable illnesses in the country today."

Dr. Clark's objective for the nearly 400 patients per month who are now treated on an out-patient basis is *sobriety* -- a prerequisite for getting at any of the underlying psychological or social problems that may be disrupting the patients' daily living. Twenty to 30 per cent of the patients do achieve sobriety -- a shaky state with a disease that never quite gets "cured" -- others reach different levels of functioning. Alcoholism, says Dr. Clark, is found even in teenagers and the elderly, although the late '30's and early '40's are major crisis years when the medical complications of long-term excessive drinking and family break-ups are most likely to occur.

In the fall of 1969, the first person was hired for the program, sponsored by a Cambridge-Somerville community mental health grant, and group discussions began for the alcoholic and his family. Many patients are referred by social service agencies, a number from the accident ward of the hospital. Group meetings, currently held four days a week, are not psychiatrically oriented, but are designed to educate the alcoholic in healthy living patterns for today's undeniably complex society. The objective is to communicate to the patient: What does it mean to have a drinking problem? How do you stay sober? What are the underlying problems that you face each day? How should you manage these problems without alcohol? And patients are helped to work through their social problems with the aid of social service and alcohol program case workers.

The staff consists of an internist, two social workers, a public health educator, a community mental health nurse, and ten counselors, not all of whom are yet hired. Some of the program staff have developed counseling experience from a long association with Alcoholics Anonymous or Al-Anon, a community organization which serves families of alcoholics. In line with current thinking of community health planners, alcoholism counselors are not highly trained mental health professionals, but are paraprofessionals

from the community they are serving. They are "sensible, mature individuals, sensitive to other people's needs" and specially trained to deal with the needs of alcoholics and their families.

After July 1 when Dr. Clark enters the program full-time, he hopes to institute provisions for community education to prevent alcoholic problems: "Drinking does not prove one's masculinity; it does not cure depression, nor do most alcoholics drink because of some moral or character defect." He hopes, furthermore, at some point to expand the planned community-sponsored 18-20 bed halfway house for alcoholics, soon-to-be-opened near Central Square. Other projected programs include rehabilitation and vocational training, and general expansion to provide facilities at the neighborhood level.

In 1967, a local police study turned up some evidence of marijuana, some L.S.D., and very little else. In just about three years, according to Dr. Hartgering, the city has gone from an almost non-existent problem to very significant heroin usage with arrest rates climbing alarmingly. A study by Cambridge Community Services of 100 heroin addicts pointed out that of the group, 40 were born in Cambridge, and 75% of the group lived in Cambridge -- meaning that a majority were not just a transient population. In November, 1970, a pilot phase of a drug treatment program began at Cambridge Hospital -- the result of meetings with the Mayor and the Department of Health and Hospitals by Cambridge "street people" who confirmed the heroin problem in the city. "Drug addicts are often extremely young," said Dr. Hartgering; "the girls often work as prostitutes; their lives revolve around getting drugs to stave off the pain of withdrawal." The drug treatment program, which today, in its pilot phase, handles roughly 40 addicts is a combination of traditional psychiatric counseling -- group and individual therapy -- plus treatment with methadone, a morphine substitute, and a highly effective pain killer, synthesized by the Germans during World War II. "Prior to the use of methadone, studies placed the 'cure' rate for heroin addiction at about 5%," said Dr. Edward Khantzian, chief of the psychiatric consultation service at the hospital, and head of the drug treatment program. "In New York and Washington where programs are currently underway, 70-80% of the patients are now off of hard drugs."

The current methadone maintenance and detoxification program at the Cambridge Hospital has the potential of treating 75-100 people concurrently once it gets fully underway this summer. Patients meeting the criteria for detoxification are given methadone to minimize the problems of withdrawal. For most patients, however, methadone treatment is most successful in a maintenance program,

where the drug dosage is gradually increased to a level necessary for functioning. The effectiveness of the drug (taken mixed with Tang, and available under strict control only at the Hospital) lies in the fact that the addict stops craving narcotics; he feels "contented." "Heroin is fast acting," said Dr. Khantzian. "The addict most constantly worry about the withdrawal; whereas methadone, a more stable synthetic, takes about 48 hours to wear off. The obsession with withdrawal is put off; and the addict knows he can get more." Methadone produces no "high," and, while in the user's system, produces a "narcotics blockade" which prevents him from getting the euphoric "high" induced by heroin.

Addicts are referred to the program through word-of-mouth and, most often, by the police. "In working with the police, we can fall into the situation of looking like 'do-gooders,'" said Dr. Khantzian, "protecting someone against the 'due process of law.' But sometimes police are too punitive or suspicious, and not aware of how important it is to keep patient matters confidential. Addicts often don't trust anyone -- a basic problem -- and by violating their trust we could undo much of what we are trying to achieve."

Part of the drug treatment program is also to include job counseling and retraining under the direction of Lana Kennings, a veteran of five years of similar job retraining programs for addicts in both California and Honolulu. She hopes to develop a program of short-term job retraining in Cambridge where addicts, some of whom prior to their addiction held down professional or skilled jobs, get the chance to return to productive work. "Today the public attitude towards drug addicts is what it used to be toward alcoholics ten years ago," said Mrs. Kennings. "But, from my experience, I know retraining can work. No one would ever be presented as a job candidate until we were sure that he was ready."

"Everytime I get discouraged," said Leslie MacCloud, the hospital's 29-year-old director, "I pull out the 'White Paper' report and see how things have changed." In the past several years, treatment of diseases and other medical problems at the hospital has also been greatly upgraded due to the Harvard affiliation, new drugs, new facilities, and a "hand-picked" staff. As a result, the Cambridge Hospital has perhaps even slightly fewer beds than in 1961, but there is no shortage. The huge annual deficit has also been reduced, even though the hospital still foots a \$4-500,000 bill for people served in the facilities that can not pay. "But what is being achieved," says Dr. Hartgering, "is that the hospital is becoming a neighborhood center and making tremendous progress in the quality of medical care in Cambridge."