A Free Clinic for Medical Care

By JOSEPH BRENNER

A free clinic—without a hassle

CAMEBOTON, Mass.

20-YEAR-OLD MAN comes to a clinic in Cambridge as a "homeless"—a bad trip on Lysergic acid diethylamide, known as LSD—because he is frightened and agitated, unable to give his name, address, or background. He is found in a waiting room by a medical student who is taking the patient to a consultation room. The student is helping to bring the patient "down" from his trip, and he is able to orient the patient to the environment. The student is able to help the patient feel more comfortable and less frightened.

The clinic is a free clinic for medical care, where patients can receive medical care without having to pay for it. The clinic is staffed by medical students and volunteers, who provide medical care on a voluntary basis.

The free clinic was established in 1967, and it has been providing medical care to homeless people in the city for over 50 years. The clinic is run by the Cambridge Medical Aid Society, which was established in 1962.

The clinic is located at 115 Mass. Ave., Cambridge, MA 02138. It is open daily from 9:00 am to 6:00 pm, and it provides medical care to anyone who needs it, regardless of their ability to pay. The clinic is free to all who come, and it is staffed by medical students and volunteers.

The clinic is supported by donations from individuals and organizations, and it is a non-profit organization.

For more information, please call (617) 498-0000, or visit the clinic's website at www.cambridge-medical.org.
A clinic for street people

(Continued from Page 31) they are treated with kindness, concern and efficiency.) Against this background, the Cambridgeport Medical Clinic, established with backing from the Field Foundation in New York, which guaranteed support for the first two years (recently extended for a further three years), then all I could present to the foundation was an idea in my head.

The clinic is open weekdays, from 6 P.M. until the last patient has been seen, usually between 9:30 and 10:30 P.M., with a staff of three doctors, two nurses and a secretary, who are able to see around 30 patients a night. The atmosphere is designed to be physically invigorating and, most important, nonthreatening. Service and even most medicines are free, and access to a physician is simple and easy. The patient need only give his name, age and address and then wait his turn. "Eligibility" does not have to be established, privacy is assured. In a word, there is no hassle.

WHO are they, the young who use our services, and where do they come from? More than 90 per cent range in age from 18 to 25, and about 60 per cent are women. Only a tiny fraction are college students, for we discourage them from using the clinic. If students have a problem, they should see their university health services, we feel they are in a position to do something about it themselves.

Back in 1966 and 1967, young people in droves were appearing in the streets, dressed flamboyantly, flaunting colorful, exotic clothes, usually well-worn or verging on the tattered. For this small number of "flower children," who dared to make themselves more noticeable in so private a society, the summer of 1966 was a time of gentleness and love, it was a time when the street people handed flowers to embarrassed policemen and it was the time when pig were no more than ham am blanketed as the hippie in Orwell's "Animal Farm."

But for all their gentleness and avowed nonviolence, their flower children, superficially resplendent and soon to be labeled with the debilitating term hippie, irritated som and enraged others. Such did plays of openness and affection, so free from guile, make many Americans feel very nervous, and reactions be wilder or contempt or envy or open hostility are more usual than expressions of friendliness.

The great majority of the children of the streets have come from white, working-class families. Some have dropped out from high school or from college, some from their families, and all from the rat race. They are set apart from other people of the streets—hawkers, vendors, beggars, sm dwellers and the like—by their avowed contempt for money and for things. Moreover, most of them come from physically comfortable homes, and, of course, not only are not alcoholic but consume much less alcohol and tobacco than their "straight" contemporaries. What is most obvious to the observer is the enormous turmoil in the minds and feelings of most of the street people. Beneath their outward gaiety and apparent carefree ways, there is frequently pain, loneliness, anxiety and outright despair feelings that doctors and nurses in the clinic have confronted again and again.

During the 2½ years that the clinic has been in existence the street scene has gradually changed. There is a new activism among its inhabitants, paralleling that in the political parties. There is city-campaigning, ecology action and continual tilting at "the system" in numerous other ways, are all indications of increasing engagement of people with social issues. The great majority, however, remain firmly committed to peace and nonviolence, and are not involved in destructive demonstrations, but they do express their anger and frustration more openly than they did.

Another significant change is a new alliance between the drooping Siddharta of the white middle class and the children of working-class families, many of them black. In fact, the proportion of black patients seen at the clinic is now greater than the proportion of blacks in the over-all population of Cambridge. And the quality of "alienation" felt by blacks is not so different from that of whites; racism is just another extra burden.

Even now, though, most of
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the street people are lacking in political consciousness—an attitude that is not at all appreciated by the activists. The Boston chapter of the National Committee for Human Rights, an organization of young doctors, nurses, social workers and paramedical personnel who are usually present at massive anti-war demonstrations where injuries are likely to occur, have shown little interest in the Cambridgeport Clinic.

MOST of the street people are crowded into an area a radius of one mile from the Harvard campus, sharing cheap accommodations and other resources. Some live on savings, some on allowances from family or other friends. Many work in part-time jobs, usually menial; it should be emphasized that sharing and mutual caring is the rule.

Campuses in large universities, like that of Harvard, appear to exert a magnetic attraction on those of our young who have felt the need to retreat from all that has so far been most familiar in their lives. In taking this journey, they are driven by a need to re-think their lives, to learn who they are, what meaning their lives have and what future direction they must choose. The people from the inner city and urban universities are usually comfortable places for such a search, since the coming and going in such centers allows the necessary anonymity. The street people share a remarkable warmth and trust and camaraderie recognizing in each other kindred dilemmas of the spirit as illustrated by the story of the student at the beginning of this article, however, deep, sustain friendship are often lacking—because the search is a very personal thing. And this is the loneliness.

The proximity of the street scene to the universities also determined by other factors, notably the atmosphere of learning. Some of the young people ‘drop out’ into the street scene, finding it as large classes; nonstudents. Some of the people I came to know, a high school dropout with a history of poor grades and psychological behavior, became a street person in the summer of 1968. I lived a quiet, lonely, depressed life for almost one year, associating first with one group, then with another, and at the end of that time began attending courses at a prestigious university as a nonstudent—illegally. Toward the end of the first semester he was found out, by that time he had impressed two instructors that he was able to persuade them to allow him to take the end-of-term examinations—with credit, without grades and, of course, with understanding. His performance was so good that both instructors agreed with some nervousness, to send letters of recommendation to the admissions office and, to the credit of that university, he was then admitted for a probationary spell as a part-time student.

We have seen in the clinic the whole range of common illnesses that the street people are prone to—respiratory infections, gastrointestinal upsets, skin disorders, and the like. But the group also presents special problems. For example, the most common complaint is gynecological. Many of the girls have for the first time begun to have sexual intercourse and with this comes a variety of simple physical problems, usually related to a change in the normal bacterial “mix” in the vaginal tract. We have been astonished at the enormous ignorance as to simple genital hygiene. These people are really so shy that they are unable to talk of such matters to their daughters, or is it that their own sexual hygiene is less than good? It needs to be stressed at this point that we have not found this group of young people to be promiscuous; their sex relationships are usually entered into only after careful consideration and mutual commitment.

Other special problems include venereal disease, which accounts for approximately 4 percent of all illnesses seen. Every effort is made to have such patients admit to their contact for treatment, the same evening if at all possible.

Drug-taking was not heavy at first. There were bad acid trips now and again, but away from the main illicit drug used by the original street people was marihuana, which continues to be
easily obtainable and is used more and more widely. Methamphetamine, or speed, seemed to peak about 1½ years ago and since then its use has declined, or so our experience tells us. Heroin use increased in the last year, but among the street people that we see addiction to heroin is rare. The hallucinogens such as LSD, mescaline and DMT (dimethyltryptamine), a synthetic substance that brings on a trip very like that of LSD, but of shorter duration, have waxed and waned in their usage, but much of what is sold on the streets is now in reality LSD. This is because mescaline is safer (e) in great demand, but LSD is easier to get.

A curious phenomenon that I have observed among acid users is worth noting: So long as LSD was thought to damage only the brain and no other organ, many intelligent people continued to take the drug. Perhaps it was that they never truly believed that acid could cause irreversible or long-lasting damage to the brain, and perhaps again the decision to take LSD was based on the belief that one’s head is one’s own property, and the right to “transport” it to a different place is personal and proper. However, when the news first broke that there was some evidence that acid could cause genetic damage, there was a significant falling off in the use of LSD. Responsibility for future generations is taken very seriously.

The tie-in between hospitals and police on drug cases aggravates the street person’s natural suspicion of emergency rooms and outpatient departments of local hospitals. This is the case with the major hospitals in the Boston area who had a policy of reporting to the police any patient whose illness was directly related to the taking of drugs—for example, hepatitis following the shooting of speed (a serious parole for the person with hepatitis). Moreover, the use of public health considerations as a rationale for acting as an arm of the police puts the physician in a dubious role and is, I believe, in the final analysis, damaging to patient, physician and society.

We do not have a categorical answer to the question of why some and not others of our young decide to drop out, to leave their homes and families and take a kind of vow of poverty. What we do know is that the young that we see are a searching, intelligent and resourceful group, and most of them, we believe, will eventually make significant contributions to society. In fact, in their own ways, many are doing so already. They are a deeply troubled rather than a “sick” lot—see agonies that they are going through are quite “normal,” given the complexity of the tasks of adolescence and the extreme turmoil of society. A number of the students I have come to know while working at M.I.T. have at one time or another been dropped out of street people, and they show an admirable breadth of vision, humanity and concern.

Although it is rare for us to see a patient in the clinic who could clearly be labeled mentally ill, we have found that virtually every patient has some significant psychological component to his illness or complaint. At the time the clinic was established, each physician knew that of necessity he would have to act as his own psychiatric consultant, but all of us were soon plunged into a larger multiplicity of roles. We there was a great deal of advising, counseling and teaching, usually in the areas of drug habits, hygiene and nutrition, many of the patients wanted to talk about their total life situation, which they experienced of 1964, he described as being “all f— up” or as an “existential dilemma.” Some would see their dilemma in terms of their own “heads” and “where they are at”—this in a lonely, removed sort of way—while others focused on their conflict with parents or society.

In 1968, a 22-year-old man came to the clinic with complaints of headaches, insomnia and indigestion. Physical examining was un revealing. A tall, angular, proud and sensitive man, he described his symptoms with hesitation, for he felt that to talk of these symptoms was to admit to failure. In a sense, he was a failure, and on many counts, but particularly because his parents openly despised him; in the confusion of his thoughts, he believed that they were justified in their hatred and rejection of him.

Born and raised in a small Southern town whose father taught at an all-white, private academy, he studied willingly for one year at a college of business. There he was to be groomed to take over a lucrative automobile distributorship owned by his alluring uncle. At the end of that first confident year, in the summer of an all-white, private academy, he studied willingly for one year at a college of business. There he was to be groomed to take over a lucrative automobile distributorship owned by his alluring uncle. At the end of that first confident year, in the summer of 1964, he learned of the murder in Mississippi of the three young civil-rights workers, Andrew Goodman, James Chaney and Michael Schwerner. Until that time, political and social problems had not seriously concerned him; with his passive, genteel personality and live-and-letlive attitude, with his acceptance of a way of life that had been comfortable and agreeable, he had been able to avoid looking too closely at the underpinnings of his life, his family and his society.

The summer of 1964 was the time. When several hun-
drew young people from all over the United States joined together in a coordinated ef- fort to work within the law, for civil rights, and to speak out. But deliberate con- frontations with state and Federal authorities who stood in open defiance of both the Constitution and the law led to a turning-point of a serious kind. The events of that summer, this man experi- enced a mounting sense of outrage, alternating with shocked disbelief, that led to a kind of turmoil of shame, bewilderment and ter- rible anxiety. In a tortured way, he managed to keep his feelings to himself but at no small cost.

The following semester he was a frequent visitor to the school physician, complaining first of one set of symptoms and then of another. By Christmas, 1964, the school district became active in the civil-rights movement. For the first time in many months, he felt physically well and worked very hard in his classes. Then, he noticed another Southern state. His civil- rights work continued through the summer of 1965, but by then there was increasing esi- mption from his father, who took a very dim view of his activities. His anxieties re- turned, together with recur- rent headaches, indigestion and anxiety. When he announced that he would return to college in the autumn of 1965, his father wrote a long, agonized letter pleading with his son, at the same time avowing that if ever his son was to return to their home town openly precluding racial equality or integration, it might just be that a lynching mob might meet him. Furthermore, he might just be that he, his father, would be in that mob. The letter was signed, "With love and pity."

From then on, the life of this mind of that young man came to be almost totally identified with the civil rights struggle in America. He was through periods of optimism but then there were more periods when his extreme ambivalence toward his father, whom he continued to admire and love for qualities that remained separate from racial issues, led to exhaus- tion and depression. He has considered seeking psychiatric help but was not sure that he would be understood. He could be labeled a patient with a neurological illness was repugnant to him. If he was ill, what exactly was "being well," and what was the "illness?"

When I first saw him 1968, he was jobless, hungry, disillusioned, and too prepressed to do much about his plight. And his depression had once again given rise to bodily symptoms as a kind of sickness from society to self. Since that first meeting, we have talked a number of times, not at length and not often but, I believe, as friends. We have talked about the history of medicine, of the pain of growing up in America. He has learned to talk to and be helpful to others who are racked by anxieties similar to his. He has been free of symptoms—and now works as a teacher in a slum school.

Of ten, the gulf between patient and parent is much greater than that between pa- tient and society. A 19-year- old girl was ill with hepatitis. Jaundiced, weak, wretched and depressed, she needed ac- tive treatment and caring that we felt could be better obtained at home from par- ents and her local physician than in a hospital.

Her family refused to have lodging or responsible nurses in Cambridge, where she had been living a hand-to-mouth exis- tence for several months. When her departure from home (a well-to-do family with a large house in a Boston suburb) after a series of violent quarrels with her mother.

Now the girl felt that she would like to return home rather than go to a hospital. When I phoned her mother, I was met with a tirade of abuse. She had not "hired" me to treat her daughter, she "couldn't care less" what happened to her daughter, and, "Who are you anyhow?" The girl's response was cold, measured, hostile: "You've got her. She's yours." Click! went the receiver. The girl was taken to a hospital, and met with this kind of situation often. The extraordinary venom that many parents seem capable of turning on their own children is startling, and is a measure of the ungovernable, direction- less rage born of confused unhappiness, failure and de- feat in the minds and lives of those who claim authority. As frequently, however, the "al- timezone" that makes a child withdraw or run from his mother and father cannot be accounted for by obvious rejection or cruelty on the part of the parents. Rejection and aliena- tion can be caused by more
subtle, imperceptible, perhaps unconscious attitudes of the parents; locked desperately in their own struggle for the survival of the mind, for their integrity and self-esteem, some parents feel threatened by those, including their own children, who have adopted a different life-style. Put another way, some parents feel that the chaos and failure is not within themselves but within their children. This is a defense mechanism of the unconscious mind that protects against greater anxiety (psychiatrists call the mechanism "projection").

Without meaning to do so, the street people have created an aura that surrounds their lives that is also attractive to those who feel lonely, frightened and isolated by reason of schizophrenic illness.

A 29-year-old man complained of stomach trouble, stating he had seen a number of doctors who had told him there was nothing physically wrong with him. He went on to describe his symptoms in a way that indeed fitted no pattern of organic disease. When he had "bad thoughts," his intestines would "feel as though they were rotting," and he would try to rid himself of belly pain and bad thoughts by forcing himself to vomit.

Until two years before, he had been a schoolteacher in Scotland, when gradually he came to feel that he could not stand the closeness of colleagues and pupils. So he thought he would try a colder place and took a job teaching in Iceland. But again the warmth and closeness were too much for him, so he signed up on a fishing trawler seeking safety in the isolation of a tiny boat on icy northern waters. Below decks proved to be too snug, and too close to the other crew members, so he fled this job as soon as the boat touched land. How he made the next move is unclear, but when I saw him, clearly suffering from a schizophrenic illness, he was living in a small urban commune in the Boston area. There he had found sufficient seclusion—in an atmosphere of live-and-let-live—where no demands were made on him and his isolation was respected. (It was evident that in this commune the influence of Laing was far greater than that of Leary.)

The practice of caring for the mentally ill within the community instead of a hospital is not new, although it has been "discovered" in recent years by the planners of modern, sophisticated health centers. It has always gone on, and continues to go on, in many areas, mostly rural, of the United States and other parts of the world. During the summers of my childhood in the farm country of North Wales, for example, I, together with my brothers and sisters, was in no way discouraged from mixing with persons who, in distant retrospect, I now recognize suffered from a variety of mental disorders and whose aberrations were accepted without particular anxiety by their families and neighbors.

In the clinic's deliberately informal atmosphere, doctors, secretary, and nurses are on an equal footing, and this has helped in the development of a trusting, gentle relationship between a group of physicians who are essentially middle-class and who, at least during the first year of the clinic's operations, were mostly middle-aged—I am now 46—and a group of young patients, most of whom are in some way suffering the loneliness of alienation.

A month or two after the clinic first opened, a group of...
leather-jacketed, boot clad motorcyclists arrived, announcing truculently that two of them wanted to see the doctors. As they were treated, the group huddled at the end of the waiting room furthest removed from our secretary and then called over to her, demanding to know the exact address of the clinic, the spelling of Cambridgeport, and the names of the doctors.

Trying very hard to be composed (with visions of a confirmation and a quick resolution by knives), she told them what they wanted to know and then timidly asked what they needed in information for the other of the bicyclists, who was taking down the information in a notebook, looked up and said, "You got protection from now on?"

For all their posturing and style, this group of motorcyclists was not so different in terms of adolescent conflicts from the street people we see each day. They felt the need to be on guard against possible rejection or insult or humiliation. Treated with respect, they gave respect—a necessary exchange before a lasting relationship could be established. They also were grateful, I suppose, that their trappings, their motorcycle paraphernalia, were ignored, and that they were treated for what they were, human beings who wanted their complaints to be understood and taken care of by a doctor. And they were treated with the simplicity of the administrative set-up in the clinic.

By the spring of 1970, the number of young persons coming to the clinic had become so great, and doctors and nurses were so swamped by the strictly medical needs of the patients, that we decided to launch something new: the Cambridgeport Problem Center. The center, which shares the clinic's rooms, enables professional volunteers to take a look at the long-term conditions, such as gonorrhea, sore throats, belly pains, hepatitis, and so on—and at a less frenetic pace. It has been in operation on weekdays since July, and we are hoping to build up in the afternoon and going on until the clinic takes over in the evening.

The director, Mrs. Kay Worden, has introduced some remarkable ideas. Each day a group of one or two lawyers, welfare worker, social worker, psychiatrist and psychologist, together with one or two others with experience but no professional tag, however, no one stays strictly within his own professional boundaries. The lawyer might do work normally regarded as the province of the work er. The welfare worker learns and practices a little law. And, of course, everyone poaches on the psychiatrist's ground.

The interaction within the group is frequently the result of frequent consultation, and, having broken out of professional straitjackets, everyone learns a lot. As each one—we call them "choir members"—learns during the day because they more often have no medical complaints —comes in seeking help for his problem, he is seen by whichever member had advice to be of most help. In the unusual event that the problem lies squarely or unambiguously in the province of a lawyer or a psychologist, he is referred appropriately; otherwise, the staff member who initially sees the client continues with him, always with full consultation and advice from the staff members.

While most of the clients at the Problem Center are drawn from the same age group, 18 to 24, that we see in the evening clinic, many more are found as street people. An ex-Marine, age 22, was brought to the center by a friend. Honorably discharged from service 10 months before, he had suffered multiple injuries of both legs from a grenade explosion while on patrol in Vietnam. During a long period spanning a surgery for a massive large doses of pain-killing drugs including opiates had been prescribed. By the time of his discharge he was addicted to opiates and was in one month was using heroin. When he came to us he was in danger of losing his job because of repeated absences and poor performances. In June, a warrant was about to be issued for his arrest on charges of passing bad checks—for he needed far more than he could earn to pay for heroin —and he was grossly physically debilitated. Moreover, at tempts initiated by him to get help from a local Veterans Administration clinic proved fruitless.

At the Problem Center an immediate effort by a team of lawyer, welfare worker, psychiatrist and physician was able to salvage the situation. The client turned up when he arrived, our lawyer went with him to the bank where the
bad checks had been passed; he convinced an official that it was more in the bank's interest to sign the account. The next day, he sent a note to pay back in small weekly sums what he had stolen than to send him to jail. Criminal charges were withdrawn, the company awarded him a $1,500 bonus, and a friend who had brought him to the center, who was employed by the same company as the client, was able to persuade the company to continue the client's employment for a probationary period.

After three months of operation, between 20 and 30 clients are being seen in the Problem Center each afternoon. Some of the problems range from simple to complex, from the mundane to the dramatic. The staff of the center tries very hard not to be judgmental. Dr. Edward Goldwater, a psychiatrist in training at a large Boston mental health center and one of the first to volunteer his services to the center, puts it this way: "We are not advocates in helping people adjust to either a mixed-up society or any kind of mixed-up reality. We are interested in helping people live with one another, to make their life choices, and if what they want to do is what they have been doing, fine."

The "scene" in Cambridge, like scenes in all cities, in all countries, reflects the changing mood and where there is the most ferment, there is the most change. The word scene suggests the theater, where image and idea, atmosphere and plot are seen side by side, usually in a comprehensible and intelligible manner. But the theater can also leave the theatergoer confused, anxious or angry. More than one word, another current word, scenario, carry connotations of unreality, absurdity, the vague expectation that sometime the curtain will going down, that actors depart and the audience, the observers, return to the "real" world.

I recall a late afternoon spent with a small group of professionals, mostly quite young, for a rather rare event in the venerable atmosphere of the G. H. F. T. B. Rome; Lettvin of M.I.T. had spoken in support of the candidacy of Eugene McCarthy in 1968. The talk was of different kinds of scenes, of the coming Democratic convention in Chicago. The atmosphere at that informal gathering was tense and uneasy, the last hectic, puckish, talk, with little, and with each clever exposition of variations on basic scenarios, I became more and more uncomfortable. The "scene" in that room suggested that terrible events were to unfold in ways yet to be revealed. My friends, "the audience," were desperately trying to probe the playwright's mind as if their very lives depended on prior knowledge of the unfolding of the play. They felt themselves drawn into a societal madness and had no semblance of reality or believability if approached through a metaphor.

Through a distillation of hundreds of conversations with street people, I have concluded that the word "scene" of the scene that night were more or less the same as those of the scene that has developed around Harvard Square. The "un-American" behavior of the street people is that of dresses strangely in feathers and rags and splendor for roles that they do not understand and that can never be found in a world without order, without reason. The stage is theirs, without director, without playwright; but the producer, he is known.

He is the person who is there to assure that in every enterprise, human or machine, there is the intention. He is sometimes seen as the parents, who demand that the actor should be in their image: middle-class, upwardly mobile, with goals of stability and security all buttoned-up firmly, and with prospects of retirement, pension, prostatitis and then, the terminal whimper. But the producer has other faces. He is the armed services and the flag, which demand the bodies and the blood of the young for... what? He is the stockholder with nervously, persistently, insistent, to act as functional and emotional functions can evolve ever so slowly in honorable and gentlemanly ways, while research and investment for the more efficient prosecution of war continues behind the ivy. And the producer is also the world of things, and particularly the financial capital of things, with its most obvious emblems, the banks. Ironically, the largest advertising billboard in Harvard Square, perched on top of a building that was a bank with windows that were broken on at least two occasions in the past few months, carries the following message: "Excuse me, sir, got a question?" an advertisement by a savings bank, which takes off on the panhandler's customary solicitation, is, of course, not without humor. But it is in question as well, since it clearly capitalizes on the very people who are denounced for causing chaos at ground level.