Courage, Innovation, and Discovery in the Development of a Medical Career

RICHARD D. BUDSON, MD

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Preface

- Have you ever had to choose between doing what was expected of you and doing the right thing?
- Have you wondered what it is like to be a doctor in a busy emergency room?
- Have you ever thought about what you would do if you were a medical student or a young doctor and your patient wasn't getting the best treatment?
- Are you a physician with ideas about curing illnesses in new ways but afraid to find out if your notions are right or wrong?
- Do you want to know more about the altruistic and creative venture of medical practice?

If you responded yes to any of these questions, this is the book for you. Consider these challenging situations:

You are a brand-new physician interning in a downtown urban hospital when five White policemen bring a Black youth into your examining room—and begin to assault him. What would you do?

You are a young doctor examining a patient you just admitted to the hospital with diabetic acidosis at 10 PM and you discover a large hole in the roof of her mouth. How would you solve the meaning of that unusual finding? (And what would you do when the attending surgeon refuses to act?)

You are a medical student and enter an emergency room to visit a friend who wasn't feeling well. You see in an instant that she is pale, clammy, with a racing heart and a blood pressure of 80 over zero. You're worried that she is bleeding internally, but there has been no attention paid to her by the ER staff. What would you do?

You are medical student on the team doing open heart surgery in the early days of heart-lung bypass machine, and you witness four consecutive patients bleed to death several hours after an apparently successful operation. In each case you watch the frantic surgeons looking for a bleeding vessel which is never found. You have an idea that the problem is due to something else entirely, but you're just a student. What would you do?

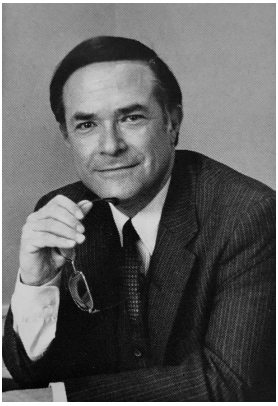
Read this book and you will see how these unusual, but real medical situations were evaluated and solved by the author.

I have had an exciting medical career, but the stage was set in my high school years where I was the leader of 45,000 students trying to quell race riots in Detroit. As a student at Harvard College, I successfully helped the mentally ill in ways thought not possible. As a medical student and young doctor, I made several novel discoveries. I finished my career as Associate Professor of Psychiatry at Harvard Medical School, where I was the world leader in residential care of the mentally ill.

How did I accomplish all these things during my education and subsequent career? I recognized my talents and strove to make effective use of them. I took advantage of opportunities as I encountered them. I sized up unexpected, unusual situations, thought carefully about them, and sought logical—

although often unconventional—solutions. I didn't shirk from doing what I thought was right, whether that meant working to discover a new truth that could lead to the betterment of mankind or working to provide the best care to the patient in front of me. As you'll see, I often had to challenge the existing authority.

I invite you to dive into this book with the hope it might encourage and inspire you to see what is possible, to take note of your talents, and to use them for the betterment of all.



—Richard D. Budson, MD

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Courage, Innovation, and Discovery in the Development of a Medical Career

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Chapter 1

Early Themes Establishing the Underpinnings of a Future Medical Career

Surprisingly, this book starts before medical school—even before college—when, as a senior in high school, I unexpectedly found myself in the center of a serious problem throughout the City of Detroit (population 6,421,000) that, as high school president, I had to solve.

In 1952 I was 17 years old and a senior in Mumford High School in Detroit, Michigan. It was one of 20 high schools with 45,000 students in the city. Arthur L. McGrath, a Harvard alum, as Assistant Superintendent of Schools, was in charge of the high schools. A serious crisis of increasing rowdyism was occurring in those schools, particularly around sporting events. For example, groups of teenagers affiliated with gangs were arrested for possession of liquor, others carrying an eight-inch billy club and a blackjack weapon were seized by police, a 17-year-old rooter "was mauled by six youths on the opposite winning side," and "there were some beatings at recent games." Mr. McGrath said to the Detroit Free Press that, "I don't know where the solution lies. If I did it would be in effect." In a feature article about the problems, the Press went on to say, "Meanwhile, officials

took a positive approach, involving the Intra-Metropolitan Student Sportsmanship Council and the use of sportsmanship flags donated by the St. Cyprian's Men's Club." On October 11, 1952, Mr. McGrath was reported in the Detroit Free Press to have said, "In voicing his concern about the violent outbreaks... he was willing, at least temporarily, to let the students work out their own solution through the council. But if it continues, we will have to invoke the final extreme expedient of canceling (football) schedules."

As President of the Student Council at Mumford High, I was a member of the Intra-Metropolitan Sportsmanship Council—and I had just been elected President of that all-city Council. In that position I and my Council were challenged by Mr. McGrath to stop the rowdiness, the fights, the drinking, and assaults throughout the city or he would shut down the athletics program. This was an important issue for the city as there were subtle overtones about racist gangs and bad memories of race riots that occurred during World War II. So, the task was not only stopping the rowdyism, but also enhancing good interracial collaboration and camaraderie.

Our team to address this challenge was, fortunately, up to the job. The Intra-Metropolitan Student Sportsmanship Council itself was made up of forty gifted and talented students, two from each high school, who were already leaders—President and Vice President—of their respective high school. In addition, we had a faculty advisor, Wesley Rea from Northeastern High School, whom all the members liked and were comfortable with. Thirdly, we were very fortunate that a sponsoring group within the community, the St Cyprian Episcopal Church (an African American church), supported the Council's work. The Church

was to ultimately purchase and provide the Sportsmanship Flags that we featured in our program. So, we set out to defeat the rowdies—and flip them from "hero" status to "loser" status.

Detroit Free Press

Rowdyism Perils School Grid Schedul

ommunity Leaders and Students Spark Sportsmanship Rally

TEEN NEWS and VIEWS

IMSSC SPORTSMANSHIP

Detroit Free Press covers rowdyism in schools and efforts to curtail it.

We started an intense public relations effort. We held sportsmanship assemblies in every high school where we (the school's President and Vice President) addressed the entire student body, explaining how their school will receive a special "sportsmanship flag" to be prominently flown from the flagpole, just beneath the American flag. If there is any rowdiness at a game involving their school, their flag will come down for a specified period—and that will be reported in the Detroit News Sports Page on a weekly basis. In addition, we—and other students who

were similarly minded—engaged members of the gangs and convinced them to cease the violence in their schools.

We worked hard to publicize these efforts. We went on television shows to discuss the situation and our plans to address the rowdiness. There were events and speeches at many of the cooperative churches in the city. This was a rare but successful example of coordinated multiracial effort. The Council initiated "Sub-Sportsmanship Councils"—a group of students in each school to help develop their sportsmanship program.

Here is what was presented at a Central High School "Town Meeting" reviewing the effort of seven attending high schools:

Chadsey High School: "At Chadsey 10% of our entire student body has voluntarily joined the school sportsmanship sub-council."

Eastern High School: "Members of our school sportsmanship sub-council go to homerooms to urge their schoolmates to act in such a manner as to bring credit to themselves and the school."

Mackenzie High School: "At Mackenzie we had a dance following our basketball game with Cooly H.S., our opponents, as our guests."

U. of Detroit High School: "At our east-west championship game with EASTERN the Sportsmanship Code was read before a crowd of about 15,000."

Denby High School: "We are trying to improve relations in the Denby area by the publishing of information about sportsmanship in both the school and the community papers."

Mumford: "At Mumford the sportsmanship code has been printed on our athletic programs for the students use."

Northeastern: "At Northeastern we have had student exchanges with Northern, Denby, and Miller High Schools and found them very successful."

With this kind of school-by-school effort, each applied in a manner most effective for their situation—backed up by multimedia appeals in television and newspapers—the entirety of the rowdyism ceased. The fights stopped. There were no more assaults. And, by the end of May, seven months after Mr. McGrath laid down his ultimatum that the fights and other rowdyism had to stop—they did.

IMSSC Climaxes Year of Work With Day of Fun at Belle Isle

Teens Promote Better Relations Through Gag Field and Track M

THE INTRA-METROPOLITAN Student Sportsmanship Council held their annual Play Day at Belle Isle last Wednesday as a final gesture of the school year to promote better relations between the high schools of the metropolitan league.

Sixteen students from every high school participated, making a total of 300. The purpose of Play Day is to help the students from different high schools become better acquainted by mingling together in a pleasant setting away from the tensions of an athletic contest with the hope that they thereby will become ambassadors of goodwill and relate their enjoyable experiences to their own school chums.

On the program for the day was a "gag" track and field meet. Each of the 14 teams was composed of one student from each high school. For the first ev each team was given minutes to become acqu ed and to originate a yell. Thus, at the ver glossing, students from the high schools were ing together as a team

EXPERIENCE

TE

Clubs With a Purp Over Social Groups

CLUBS WITH a purpose seem to hold preference over those with purely social aims at Mackenzie High School. Proof of this is found in the popularity of two of the clubs that inspire members to do some real thinking—one

together the students from tries who are school.

Students wh in biology sp time to good Bio-Sem Clu

The three-legged race was won by Seymour Odler of Mumford and Levi Davis of Miller. Co-operation did it.

Picnic on Belle Isle

In a celebratory all-day picnic on a Saturday on Belle Isle (a large island in the Detroit River) we held a wonderful interracial party with games, food, good feelings, and high spirits as we demonstrated camaraderie, good sportsmanship, and fellowship. As the reader examines the aged photos on these pages, they will see the earnest intensity, high spirits, and racial integration achieved at this time. Look at the photo of the Black and White youths arm-

in-arm with huge smiles as they won the three-legged race, and remember that this was 1953—years before the civil rights movement. These photos demonstrate that not only did we win the bet with Mr. McGrath, we achieved a lasting fellowship among the high school students throughout the city.


At Sports Bust

OUTSTANDING public figures were the rule rather than the exception at the Second Annual Sports Bust sponsored by the Men's Club of St. Cyprian's Episcopal Church, Friday night. The affair, commemorating the successful program to combat high school rowdyism at athletic events, was chaired by sportscaster Van Patrick. Wally Weber, of University of Michigan, was guest speaker. Above, left to right: Arthur L. McGrath, Ass't Superintendent of Public Schools; Vaughn Blanchard, Di-

A young Dick Budson being thanked for his efforts to curb school violence

We achieved more than we could have possibly imagined. It was not lost upon us that we few student leaders of the Council had the ability and verve to engage the student body of 45,000 and have a real effect upon them as their peers. At the same time, it was a surprise to us that the professional educators turned to us to solve this problem—and the result was a demonstration of their wisdom. Our collaboration won the day. There was recognition that we were stronger together than we were alone. That recognition was an equalizer between us. Despite being below the educators on the school hierarchy, we students had a valid voice.

Unexpectedly, I reaped a startling additional benefit. Out of the blue, I received a package in the mail. It was a Harvard Prize Book, bound in beautiful leather, "offered in competition by the Harvard Club of Eastern Michigan. The

PRIZE BOOKS of the Associated Harvard Clubs shall be awarded to that student among the boys in the next to last year of college preparatory courses whom the headmasters, after consulting with the faculty and the boys' classmates, shall deem most worthy by result of high scholarship and character." I was dumbfounded; pleased but dumbfounded. To this day, I don't know who initiated this prize. Was it from the principal of my high school or from Assistant Superintendent of Schools, Mr. Arthur L. McGrath, himself a Harvard Graduate? I always presumed it was the latter, because he worked with me intimately and saw me in operation in a large arena.

A week or so later, I received a recruitment letter from Harvard College inviting me to apply. I never had an interview nor did I visit the campus. I had never even considered any other college than University of Michigan. But I went to Harvard.

Looking back, I am convinced that the ease with which I challenged authority later in life was born during my time at Harvard College, where I studied with no less than four Nobel Prize winners. These included Fritz Lippman and George Wald, both in physiology, as well as Boris Magasanik, Professor at Harvard Medical School. With Professor Magasanik I conducted research demonstrating the consequence of an enzymatic blockage in the biological pathways involving xanthine and hypoxanthine, showing unexpectedly that a pyrimidine—not a purine—backed up, causing great excitement in the lab. In the humanities I was a student of French Literature studying with Roger Shattuck, the first person to call

me "perspicacious" in relation to my work explaining the poetry of Baudelaire. We became fast friends that lasted years after graduation.

These experiences at Harvard had a lifelong influence on me. My "world famous" Harvard professors embraced me and treated me as a peer, not a subordinate. The goal was to find the truth. I was not treated as a student who was supposed to cater to authority. Rather, I was regarded as the nineteenth century French physician and physiologist, Claude Bernard, stated:

> "We are like dwarfs on the shoulders of giants, so that we can see more than they, and things at a greater distance, not by virtue of any sharpness of sight on our part, or any physical distinction, but because we are carried high and raised up by their giant size."

Note that during my experience in high school, a pattern began to emerge that you will see throughout this book, including strong empathic leadership, problem solving, engaging the public, participation and planning, and above all cooperation of all people regardless of race, gender, religion, ethnicity, culture, profession, or other characteristic that is so frequently used to divide us.

With the Sportsmanship flag

Lessons Learned

1. When you have a vast problem involving a broad range of ethnic and socioeconomic groups, develop a communication system that reaches them all equally—such as the Sportsmanship Flags and the mini-Sportsmanship Clubs in all schools.
2. Use traditional media (newspaper, magazine, radio, television) to spread your message.
3. Have representatives from all relevant groups share in the work of the deliberative bodies together as well as in planning the fun events—such as our end-of-year picnic.
4. Help to establish ethical values in the media so that those who do good are praised and those who do ill are

disparged—such as how we turned the rowdy students into “goats” and the peaceful students into “heros” instead of the reverse.

Chapter 2

Harvard Undergraduate Defeats Untreatable Psychosis

In the fall of 1955 I was a junior at Harvard College majoring in biochemical sciences as I was headed for Medical School. I was living in the beautiful Harvard Eliot House (at Harvard the student dormitories are called "Houses") on the banks of the Charles River. In addition to my science courses I had taken the year long basic courses in Western Civilization Art, Music, English writing, and French literature (which I loved reading).

At Harvard in front of Eliot House

The oldest part of the Harvard University Campus is called "Harvard Yard," which is both its historical center and modern crossroads. It contains most of the freshman dormitories. I lived in Thayer Hall as a Freshman. In one end of the Yard is a large stately building which houses the Phillips Brooks House Association. The Phillips

Brooks House was constructed in 1893 in the memory of the Reverend Phillips Brooks, a preacher at Trinity Church in Boston, a Harvard graduate, and an advocate for social service. The tradition of social service at Brooks House continues to this day. One of the areas in which it was strong in 1955 was mental health. I learned that the Association had a program with the ancient, overcrouded Metropolitan State Hospital whereby the Harvard undergraduates could go there and volunteer.

Phillips Brooks House, Harvard Yard

Most undergraduate volunteers would do such things as paint the ward or play baseball or other sports with the residents. However, I had an idea about what psychosis was about, and I thought could treat a patient there—even though I had no training whatsoever in psychiatry, psychology, or anything at all.

So, I went there and told the authorities that I wanted to be assigned a patient to treat. And, to my surprise, they said,

"OK, we will do that for you." They assigned a patient to me who was a 60-year-old woman who had been in the hospital for 28 years, since 1928. I was told she was considered "hopeless" (meaning that she could not be successfully treated) and that she spoke in a rambling, incomprehensible manner. Curiously, they didn't give me any medical record to review. I was told she was diagnosed as a paranoid schizophrenic. She had recently been started on the drug Thorazine, a relatively new antipsychotic drug taken by mouth. Dr. Neel, a woman resident in psychiatry, was assigned to meet with me regularly and monitor what I did. This was at a time before the inpatients of psychiatric hospitals were largely discharged to conform with new civil rights laws which, in effect, emptied the hospitals and increased the homeless population. I had the impression that there were so many patients in the hospital without any talking treatment that the hospital authorities were willing to accept what I offered. As it turns out, it was an entirely unique situation—apparently no one else had spent time talking with the patients! It wasn't until 1971 that the case *Wyatt v. Stickney* occurred in Alabama representing the first class-action suit successfully bringing against a state a judgement that "affirmed the constitutional right to treatment for those mentally disordered persons who were involuntarily civilly committed." As a result of this decision, for the first time a federal court dictated specific standards to be met, which had such an enormous impact on states' budgets that it led to most patients being discharged to prevent state insolvency. But *Wyatt v. Stickney* was in 1971, 15 years in the future. At the time I started seeing Clara there were enormous numbers of

patients who were abandoned and neglected in the state mental hospitals getting little or no treatment.

Today I wonder how in the world I thought I could do this? What brought me to such a mental conclusion? What motivated me to do this? There is no simple, quick, and obvious answer to this question. I was thinking quite seriously about being a psychiatrist in the future. But I had not entirely yet decided that. All I know is that I had a very simple idea: mentally ill people had two parts, a "sick" part and a "healthy" part. If one could emotionally connect to the healthy part, an interpersonal partnership could be formed based on the person's own motivation to activate their healthy part because it gave them more satisfaction than being crazy, which I conceptualized as a defense protecting them from closeness with people who they distrusted as only bringing pain. Only later in the relationship did I learn from Clara of her unrequited love shortly before she was hospitalized.

So, I began to see this patient. The trip leaving Harvard to go to the hospital was challenging in itself.

Metropolitan State Hospital | Met State...

Inside the old state hospital

This was a historic relic of a hospital with one nurse on a unit holding sixty patients. I would go up on the ward in my Harvard-required attire of the day, a jacket and tie, and walk into this chaotic, crowded hall that was a din of moaning and incomprehensible speech with bodies weaving and bending and (usually) no staff person perceptible. There was a unique stench in the facility. I was introduced to Clara, who stared at me strangely but was responsive to my instructions. It was very clear to me that almost all of the sixty patients there stopped whatever they were doing and quietly looked at my every move, as if they hadn't seen a stranger come on the ward in a very long time.

The first time I saw her I took her out of the hospital, for which permission was given. I drove to Friendly's restaurant to have a bite. I will never forget our first interaction. The waiter came to our booth and asked what we would like. Clara responded with incomprehensible gibberish. When the waiter walked away toward the kitchen, I looked Clara straight in the eye and said to her, kindly but firmly, "talk straight and normal, don't act crazy." And, to tell you the truth, I was somewhat taken aback, for when the waiter returned Clara said to his face, "I will have this sandwich." It was astonishing. In that moment I felt my theory was correct...this woman does have a healthy part. She just needed to experience someone as on her side, caring for her, and wishing her to be healthy, not sick. She complied with my request; she trusted me that fast.

As I think about my relationship with Clara, I remember these things: I was always there when I promised; I was always kind, soft spoken, caring, and positive toward her—demonstrating to her that I believed in her capability to accomplish what I

requested. I always was clear that I expected she could act sane. I wanted her to feel that I was her ally, not an adversary. Nor was I demeaning to her in any way, ever.

There was a great deal to do. Clara had been in the hospital for such a long time, she was not informed about how telephones worked, expecting an operator to say, "Number Please" when she picked up the phone. And I had to explain what traffic lights were.

I set up a schedule of coming to see her and taking her off the ward for a couple of hours every two weeks. We often went back to the same Friendly's and, if available, sat in "our booth."

Gradually, ever so slowly, she became more settled, comfortable, and at ease. By the end of the first few months her incomprehensible commentary almost completely disappeared. We took walks in the town of nearby Belmont, where I oriented her to the neighborhood. Belmont center was close to McLean Hospital, a Harvard psychiatric hospital whose staff I joined ten years later. I helped her learn how to navigate crossing streets with traffic signals. I taught her how to use a coin-operated telephone in a phone booth. Little by little she talked about her life in the South Shore of Boston from where she was taken to the hospital following a crisis in a relationship with a man she loved.

Throughout that period, I was always emotionally moved by the reception I received every time I came on the hospital ward. It was quite eerie that, as I arrived on the ward, all of the commotion and turmoil disappeared on the unit; a unique quietude prevailed in the space. All of Clara's fellow patients gazed at me silently and appeared comforted by my presence in the unit. It was as if they understood that I was a kind person who

was taking out this one patient in a way that, perhaps, they also wished for. It seemed to me unique, a bit strange, and very moving.

About every other month I met with Dr. Neel, the psychiatrist. She was convivial and interested in what I was doing; she never suggested that I do anything differently.

I learned from Clara that many years ago she had been a talented seamstress. She began to sew things, which she showed me. Gradually I saw an enthusiasm in her I hadn't seen before. I began to consider the possibility of her actually finding a job as a seamstress outside of the hospital.

Exterior of the Metropolitan State Hospital

Morgan Memorial Goodwill Industries was founded in 1895 in Boston's South End to provide residents with jobs and to furnish the community with low-cost goods. One of the things it does is to repair and sell used clothing, providing thereby both jobs for people with disabilities who are good seamstresses as

well as clothing available to the public at far below retail cost. This seemed to be just the right place for Clara. As their brochure states, "For more than a century, Goodwill has been a leading Massachusetts provider of job training and career development that help equip individuals with tools necessary to sharpen their skills, and create more rewarding and independent lives."

The staff at the Goodwill program were very encouraging when I described my hope to place a former mental patient into their facility to be able to mend their clothes which would then be for sale. I explained that she was already 61 years old and needed a stable position with no plan to transition to another job. I arranged an appointment for Clara to meet with the supervisor who was to show her the setup, explain the task of clothing repair, as well as the down-to-earth issues of times to come to work, meals available for lunch, salary, and end-of-day times. I explained all this to Clara in our next meeting and she lit up with a smile—as if she had never considered a job with a salary to be a real possibility for her.

I soon took Clara to her new job, introduced her to the sensitive, kind, supervisor. Her response was enthusiastic, in a quiet way. A starting date was settled. My next task was to teach her the geography of the location of the job in relation to the location of Metropolitan State Hospital in Waltham. We worked out how she would be transported every morning from the hospital to nearby Waverly Square, from where the buses leave for downtown Boston.

Two weeks later she started work. I had to change my schedule to meet her in the early evening after work. I visited her work once and talked with her supervisor who said she was

pleased and that there were no problems. Moreover, Clara had made friends with another member of the group mending clothes. This was a first!!

The question came up within a month: would she be stable enough to live independently, and could we find an apartment she could afford in a neighborhood within walking distance of work? After two months of commuting to work, we found such a place. I still remember opening the door for her, handing the key to her, and her crossing the threshold. She had an excited expression on her face and a happy smile. She now had a job and an apartment in independent living.

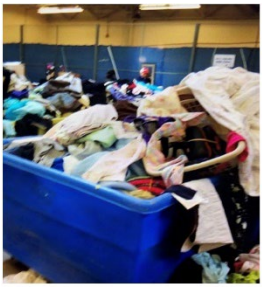
The two of us made another trip back to the hospital in a few days and I transported her entire belongings, few as they were, to her apartment, which she proudly hung up in her closet.

In the next week I went to the hospital and explained to Dr. Neel that Clara had made a successful transition after 28 years at the hospital to an independent apartment and job.

A week later my phone rang in my Harvard dorm room and a woman was on the phone by the name of Maggie Hamway. She was the secretary to Dr. Milton Greenblatt, Research Director, Massachusetts Mental Health Center. She told me that Dr. Greenblatt had heard about my work and asked if I would come to see him at his office the beginning of the next week. I meet with Dr. Greenblatt, who interviewed me daily for a week, asking me to detail exactly what I did, said, and thought while I was treating Clara, while Maggie wrote down every word I spoke. He presented a summary of this interview to the World Congress of Psychiatry in the summer of 1957 in Montreal, Canada.

The lead story of the Saturday Evening Post dated October 5, 1957, was entitled, "They Befriend the Mentally Ill," describing the story of area colleges who brought students to befriend the mentally ill with chats and games. The feature story closed describing briefly what I have described in detail in this chapter.

What I did was considered unusual and exceptional within the group of students from Harvard who came to the hospital, as I was the only student who actually treated a patient, with continuing visits for two years. I was comfortable that I did what I thought would work—and it did. I was the first student that they let help one patient go off the grounds and get well. The authority's positive reception to me was enabling and supportive. It led me to the beginning of a future career in psychiatry.



Goodwill Industries

Lessons Learned

1. Be aware of your talents, as they may direct you to your ultimate career. Testing your judgement to see if it is confirmed is important. In this situation, I unexpectedly received confirmation from the most authoritative

source, the director of research at Massachusetts Mental Health Center, leading to my work being presented at an international psychiatry meeting.

2. Explore the different decisive concepts that led to your success and evaluate the role of each. I tested the possible validity of the hypothesis that the patient had two different cognitive capabilities simultaneously: one, psychotic thinking, the other, normal thinking. I considered other possibilities, such as the one suggested by Dr. Greenblatt, that the psychosis was "burnt out" after all the years in the hospital. Perhaps the patient used the psychotic mode as a defense from insensitive staff. Whatever the cause, Clara succeeded in establishing herself as someone with healthy functioning potential after her therapeutic relationship with me gave her a secure base of support.
3. If one gets positive reinforcement that their talent is valid and likely to help contribute to a specific field or industry, they should seriously consider it as their career. In my case, I choose becoming a physician and, specifically, psychiatry for my career—and contributed significantly, as will be seen later in this book.

Chapter 3

Medical School Course by Mimeographed Notes

Harvard College was just the right place for me; University of Michigan Medical School was not. Although the student body was undoubtedly smart, through listening to the scuttlebutt at meals with my classmates, I gathered that at least a percentage of them aspired to the acquisition of great sums of money as a consequence of their medical education, looking for wealth rather than knowledge. Some of these students were also "jocks"—some actually from the National Football League—who like to act macho around the medical school campus. Even some of the faculty were macho in their own way.

I will never forget my first week at Michigan Medical School. I was sitting in an amphitheater filled with just-arrived first year medical students, when the Honorable Distinguished Professor of Embryology, Bradley M. Patten, bellowed out to all to the attentive multitude, "Look around you. Look around at your fellow students. In one year, 1 out of every 10 of you will no longer be here! Only the truly strong men will survive." I thought that was appalling—a low brow, cheap shot. Maybe you'd expect a statement like that in a 4th rate movie, but at University of Michigan Medical School?

I actually grew up under the watch of my father, a pediatrician, and my uncle, an ophthalmologist, who both graduated from the University of Michigan Medical School in 1927 and 1928 respectively. At the time it was thought to be the pinnacle of medicine. For me, it was a come down.

My son, Andrew, after graduating Haverford College in 1988 thought he should honor the family legacy and apply to the University of Michigan Medical School. As he was given a tour of the campus by a medical student guide, Andrew mentioned that when his father (me) went here, graduating in 1962, the emphasis was all about exams and grades, but surely it must be different now. "No," the guide responded, "it isn't any different now, and I wouldn't go here if I were you." He really said that. Needless to say, Andrew went to a different medical school.

Over time, I found that the school did have some good aspects. Although most students didn't aspire to being physician-scientists, most of the faculty were first rate researchers. So, to survive with my intellect intact, I conducted research in different departments along with my academic classes whenever I could.

For example, the gastroenterology division of internal medicine was trying to use a new device called the "Kirk Frei Ultramicrorespirometer" to do research on oxidative phosphorylation in liver mitochondria. The device was an elegant U-shaped piece of glass about eight inches wide with an inner pathway running between two Erlenmeyer flasks on either side. The goal was to have a specimen of biological material on one side mixed with mitochondria and the oxidation consumption rate was supposed to be measured somehow by how the oxygen was drawn from one flask to the next. I was flattered when a group of PhD researchers

working on this came to me, an undergraduate medical student, and explained that they couldn't figure out how to make this contraption work. I accepted the challenge with pleasure, excitement, and a feeling of being useful. I invented a measuring system that placed an infinitesimal drop of mineral oil into an extremely fine syringe needle, which injected the oil drop into the glass passageway and coaxed it into a center position. This allowed me to run the experiment by measuring the amount of oxygen traversed. This work resulted in the following publication: "Glucose 6-phosphate formation as a measurement of oxidative phosphorylation in liver mitochondria", by K.S. Henly, E.A. Napier, E.G. Laughrey and R.D. Budson (Ann Arbor, Mich.), Biochimica et Biophysica Acta, January, 1, 1963.

There were, however, other practices I found to be reprehensible and incompatible with a respectable medical school of Michigan's reputation and history.

In my second year of medical school, I had to take the required course in human physiology, the study of the functions and activities of the entire body, including the organs, their parts, and all of their physical and chemical processes. I was looking forward to this course as one of the most important, essential and imperative to the understanding and mastery of all that followed, including future work as a physician maintaining health, diagnosing illness, and prescribing treatments.

I was shocked at the outset of the class that there was one lecturer who gave repeated lectures, without the requirement for any one textbook of physiology to be mastered. During these lectures, it was common knowledge that members of one medical

fraternity would take notes and "distribute" them to the class before the exams. In actuality they were sold for cash as a way of the fraternity earning funds. Most of the class regarded this as an easy way to get through the class—just wait for the notes to be sold, memorize them, and take the exam. I was further shocked that the faculty were aware of this practice and allowed it to occur, thinking that this simplified, limited knowledge base was sufficient to pass the course and provide a foundation for all that followed.

I was aghast and deeply disappointed by this system as it violated my own judgement as to the importance and value of a human physiology as a subject to be discovered, argued about, investigated, and finally mastered, while keeping an open mind to new discoveries.

To deal with this dilemma and disappointment, I quietly approached the course in a manner that I judged to be adequately fitting. I searched in the Ann Arbor medical bookstore for the best and broadest set of textbooks in the field, and used them throughout the semester. Toward the end of the course, I found a treasure—a cutting-edge book by the Belgian scientist Jean Brachet, recently translated from the French into English, entitled "BioChemical Cytology" (1957). Brachet was able to show that DNA was found in chromosomes and that RNA, present in the cytoplasm of all cells, plays an active role in protein synthesis. Brachet also carried out pioneering work in the field of cell differentiation, demonstrating that differentiation is preceded by the formation of new ribosomes and accompanied by the release from the nucleus of a wave of new messenger RNA.

As the time of the final exam approached, the medical fraternity sold and distributed their version of the professor's lectures, which were eagerly sought by the majority of the students. I was not in that group. The exam consisted of ten essay questions, in which each student had to articulate his or her concept of the correct answer through written paragraphs to successfully argue their case. I was pleased after the exam that I had accomplished this task satisfactorily.

However, I was somewhat taken aback when, several days later, I received notice that a group of four physiology professors wanted to see me. At the appointed time I arrived in a relatively large classroom, somewhat like a theater, with the four professors on the stage sitting around a long table with one chair waiting for me. They promptly invited me up to join them in their "forum."

They looked at me and the faculty leader, slowly at first, explained that my final exam was by far the highest grade in the class of some two hundred students. Then, gradually becoming more and more excited in a way that suggested his incredulousness, he exclaimed, "Where in the world did you learn so much information! And who is Jean Brachet? None of us have ever heard of him."

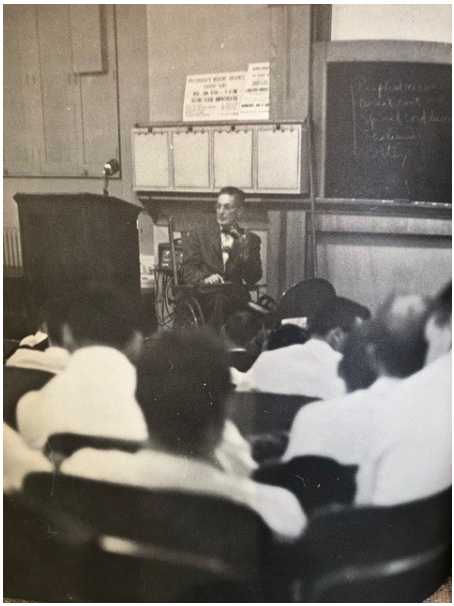
So, I politely explained to the professors, my disappointment—first of all—in the lecture form of educating, without sections where the students could discuss cutting edge issues and explore different hypotheses in small groups with the faculty. I then earnestly described my searching for a true and deep understanding of the material so that in the future I could genuinely understand my patients' maladies and their origins. I felt

that I couldn't be a proper physician without going about my education in a way that would provide deep, all-inclusive, and cutting-edge understanding of physiology that would then be a platform for my continuing medical education and the future medical practice.

I explained that I therefore went to Ulrich's Bookstore and searched for three different Human Physiology Textbooks that met my requirements. I sought books that had different approaches and perspectives that meshed with each other and would contribute to a comprehensive understanding of the complexity of the human body.

I next told them—tactfully I hope—that their system of teaching stifled instead of stimulated intellectual curiosity, which I considered the proper role of a university.

I went on to explain that the way I answered each question was an example of what I meant. Based on the knowledge I acquired in three different physiology books, I created my own intellectual discussion—which I then wrote down in my exam book that you have before you. In response to each of the exam questions, I reviewed what I learned from each of my readings, such that I said,



according to scholar A the answer might be X, and according to scholar B the answer might be Y , and according to scholar C the answer might be Z. I concluded what I believed to be the closest to reality, which may have been somewhere between Y and Z, or possibly X and Z, etc.

As far as Jean Brachet was concerned, I explained that his book was available at Ulrich's, having been recently translated into English, and how I found his discoveries to be fascinating and his research methods inspiring.

The professors were momentarily silent upon the completion of my explanation. They then quietly congratulated me and thanked me for meeting with them.

Lessons Learned

1. Don't be influenced by sloppy teaching and testing. Set your own standards and live by them.

Chapter 4

Vital Signs are Vital at Admission

After having done my best at mastering the "basic sciences" of chemistry, physiology, anatomy, pathology, and so on, I began my clinical years as a third year medical student. Now I spent my time in various clinics learning the details of cardiology, pediatrics, ophthalmology, orthopedics, and the like. I got married at the end of my second year, and my wife was teaching kindergarten in Livonia, Michigan, a nearby suburb of Ann Arbor.

Go Blue!

We were living in an apartment on Knob Hill Place, more or less overlooking the famous University of Michigan Football Stadium, which seated 72,000 people at that time. I would often hear the "roar" of the crowd when I was trying to study on a Saturday morning, realizing that while my head was in a medical book, the "Maize and Blue" had scored another touchdown.

I spent long days in the different hospital outpatient clinics. By this time, I had a considerable amount of medical knowledge under my belt and felt competent to deal with at least simple clinical situations, although always eager to be challenged in my next assignment.

One early afternoon, in the middle of the week while I was at the University Hospital, I was surprised to get a phone call from my wife. She told me she was in the Emergency Room of University Hospital with our friend, Pauline. Pauline and her husband were devout Mormons and good friends of ours. Pauline taught first grade at the same school as my wife. So, I immediately went as fast as I could to the Emergency Room.

Arriving in the Emergency Room, I was politely told by a nurse's aide that Pauline was in Room 4. As I entered and said hello to Pauline and my wife, I immediately noticed how different Pauline looked. As I stared at her, lying flat on her back on an examining table, I realized she looked "ashen." I had heard the term "ashen" described at teaching clinics and understood it to me a sign of severe anemia. In the dictionary it is described as: "ash-colored; gray; extremely pale, drained of color." I had never actually seen a patient who was "ashen" before, but I was sure that this was it.

I immediately went into a very intense mental mode, as I realized in an instant this could be a serious medical situation. Without hesitation, I decided to do a quick evaluation before I went to see what the clinical staff was planning at the nursing station.

I asked Pauline how she was feeling. She said not well since the morning, that her abdomen hurt, and that she had a strange pain in her right shoulder. I knew immediately that pain in the right shoulder can be a sign of blood in the abdomen that is irritating the diaphragm, which refers the pain to the right shoulder. I asked her if she would mind if I put my hands on her abdomen. She responded, "not at all." As I laid my hands on her abdomen, I felt that it was hard as a rock; a sign of what is known as "an acute abdomen," the abdomen's response to an urgent event usually requiring in surgery due to something like appendicitis, an intestinal obstruction, a perforated ulcer, and the like.

I then took her pulse which was 140! Normal resting pulse is 72. If you had just run a 100-yard dash you might get a pulse close to 140, but never at rest. At rest it usually means an arrhythmia or a bleed somewhere that has lowered the volume of blood in the person's arteries and the body is trying to compensate by beating faster.

So, I took the sphygmomanometer (blood pressure measuring cuff) that was hanging on the side of the wall near the bed and took her blood pressure. It was 80 over zero.

My diagnosis was that Pauline was in shock and was bleeding from somewhere within her abdomen. Blood in the abdomen was irritating her diaphragm, and she was at risk of immanent death unless immediate expert attention was given.

I walked to the nursing station and came upon a scene of several nurses present who were chatting among themselves in high spirits, without any apparent urgent matter to attend. I introduced myself as a third-year medical student who was a friend of the patient in number 4 examining room, Pauline B, and I politely asked the nurse in charge what Pauline's vital signs were. She responded assuredly, "Oh, we haven't done vital signs yet. She only has a stomach ache, and we will be down there in a few minutes." "Well," I said to her firmly, "I just took her pulse and blood pressure, and her pulse is 140 and her blood pressure is 80 over zero. I believe she is in shock from internal bleeding."

I will never forget the rapidity with which the nurses' expressions changed from joviality to alarm. They looked at me aghast for a long second and then leapt to their feet in apparent emotional agony. They ran down the hall and quickly went into action. I offered to the nurse that I think the patient may need a transfusion; "Shall I draw her blood so we can get a blood sample for type and matching so we will have blood if needed?" I asked. She agreed, and I did that and personally ran with the sample to the blood bank to order the blood to be ready as soon as possible.

There then ensued intense activity about Pauline's room. The Surgeon In-charge came to me and said he understood that I made the diagnosis. He went on to say that they have determined that she may have a ruptured ovarian cyst and needs immediate surgery. He then said that since I was so effective a medical student, he would like me to scrub in so I can personally view the nature of my discovery. Two hours later, the patient stabilized, we were in surgery. I participated by holding forceps as necessary. There was a visible lesion in her left ovary with a slow

but steady arteriole pumping blood repetitively. This was closed with ease by the surgeon and the job was done!

This was such an incredible example of how close a person can come to fatal disaster, and how with the right people, knowledge, and circumstance the disaster can be avoided.

Pauline had an uneventful recovery. She and her husband were absolutely overjoyed and eternally grateful for my intervention.

With very few exceptions, it is standard procedure to take vital signs upon admission to an emergency room. I can't but believe that these nurses who neglected procedure will never forget the possible fatal consequences of breaking protocol. To do the right thing was not difficult. Even a third-year medical school student could do it. I have no recollection of ever being thanked by the nurses. Perhaps they were too humbled by the event. But the Surgeon In-charge was gracious in his praise to me, and I have never forgotten the day that showed how vital it is to do vital signs at admission.

Lessons Learned

1. A patient should never be admitted to an Emergency Room and put into an exam room without having vital signs taken—period, no exceptions!

2. Regardless of your position in the medical hierarchy, if you see a patient who needs assistance—especially urgent assistance—speak up! It could just save their life.
3. Use these same principles in any profession. If something important is being neglected, don't simply say, "Well, it's not my job." Do something about it!

Chapter 5

The Complexity of Open-Heart Surgery with Cardiopulmonary Bypass (the Heart Lung Machine) in the Early Years

As a senior in medical school, I had a two-month clinical program assigned in open heart surgery. The first successful open heart procedure on a human utilizing the heart-lung machine was performed by John Gibbon and Frank F. Allbritten, Jr., on May 6, 1953 at Thomas Jefferson University Hospital in Philadelphia. My assignment in the fall of 1961 to open heart surgery was at a time of its infancy, just 8 years after the first successful procedure. Thus, it should be recognized that I was part of a surgical team working within the context of a new medical/surgical world where routines and assuredness of procedures were not yet well established. There is no question that the newness of the procedure played a major role in what transpired in the short time I was there.

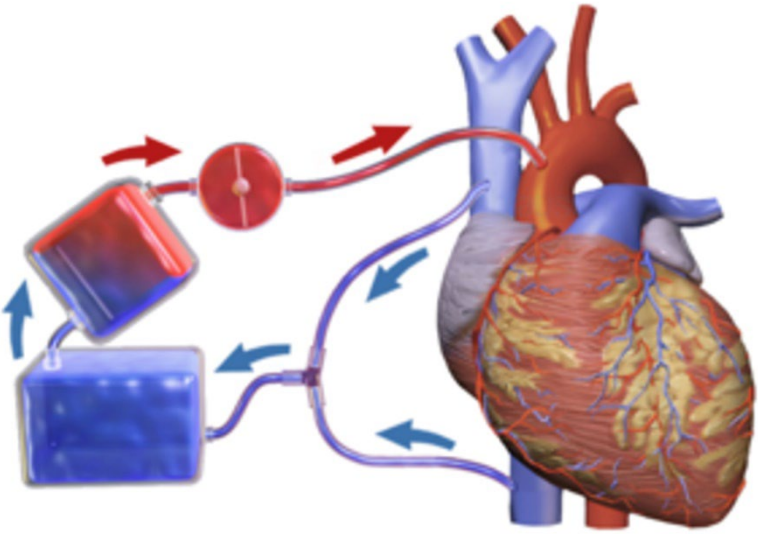
Early morning surgery was the routine. I was in the operating room area at about 7:00 AM and quickly "scrubbed in" to the surgery, donned in sterile gloves and surgical dress. The procedure was often valve replacement in a heart damaged years earlier by rheumatic fever. Operating on a rheumatic heart was

all the more difficult for the surgeon, because often the heart tissue itself could be damaged, weak, and friable. The general procedure was to bypass blood from the heart into the heart-lung machine so that the surgeon could work in the heart without any blood in it, so he could clearly see what he was doing. Tubes fed the blood to the heart-lung machine just prior to the surgery and these were withdrawn after the surgery as the blood was restored to the heart.

My role was to close the femoral incision in the groin after the surgery. This is the incision where the blood that left the body into the heart-lung machine in the thorax was returned into the femoral vein, in the upper part of the leg.

I was to participate in every open-heart surgery with my team for the two months. I recall that all seemed to be very much under control in the first procedure. The surgeon, in a very businesslike manner, approached the task with calm deliberation.

After starting at about 8:00 AM the patient had to be anesthetized, the heart lung machine was engaged so that the blood was flowing in and out of it, being oxygenized as required. After surgery was completed, the incisions sewn tight, the entire procedure took somewhere between 3-5 hours with surgery done by about 1:00 or 2:00 PM. This is what occurred the first few days.



Schematic of the heart-lung machine

However, about the fifth day, things took a turn for the worse. We had closed on what we considered to be a normal surgery earlier that day. As usual, I went home, had dinner, and was sound asleep when I was awoken at 11:00 PM by an unexpected page, telling me to come immediately to the operating room. Within a short time, I was in position with the entire surgical team. It was explained that the patient was bleeding internally, and we needed to find the bleeding blood vessel as soon as possible. The surgeon opened the incision on the chest wall and

gazed at an impressive pool of blood. There were sucking tubes to drain the blood so the "bleeder" could be found. As several minutes passed and no bleeder was found, one could see increasing anguish on the surgeon's face. The operating room became increasingly tense. Still no bleeder was found. The scene was frantic without relent. The simple task of finding the bleeding vessel and tying it off could not be done, because *there was no bleeder*. But there was unending flow of blood that could not be stopped. The patient died.

I will always remember quietly entering into the doctor's dressing room after the surgery, and seeing the surgeon, bent over on the bench by his locker, sobbing in despair.

It seemed to be such an oxymoron, this grown, strong, educated, man crying like a wounded child. It was a clear scene of tragedy.

This was the first time. Incredulously, I witnessed the same scene in the next week two more times. And there was no solution noted among the surgeon and his staff what the source of the bleeding was in any of the cases. There was a deep, growing concern in the Surgery Department because there was no solution at hand.

I thought a lot about this for several days. Finally, I came upon a hypothesis. I went to John Penner, MD, a young research physician in the Hematology Department. I proposed to him that the unrelenting bleeding with no source found at surgery was the consequence of insufficient platelets in the patient's blood stream after the surgery because the platelets were being destroyed in the heart-lung machine. Dr. Penner replied immediately, "you could be right," in a calm but firm voice. Together

we devised a research plan to test the hypothesis. I was to study the level of platelets in the blood during surgery, sampling every 30 minutes from before to after the surgery, in six consecutive patients. I was to do platelet counts on each specimen and see if there was a change from beginning to end.

Dr. Penner and I reviewed our hypothesis and plan with the thoracic surgeon responsible for this surgery. He gave me official permission to proceed with the project. I therefore continued to scrub in for all of the open heart surgeries but confined my activity to collecting the needed blood specimens. By systematically processing each vial, I carefully counted the platelets and recorded the result with the exact time in which the specimen was collected. I will note that the other professional researchers in the hematology lab were perceptively skeptical that my mission would yield any clear results.

The results were, however, quite stunning and definitive. We found a clear and steady erosion of the platelet number as the time elapsed. Those cases with a duration of 3 hours or more on the heart-lung machine with an initial count in the range of 150,000-250,000 declined to less than 70,000. And those cases had unrelenting bleeding.

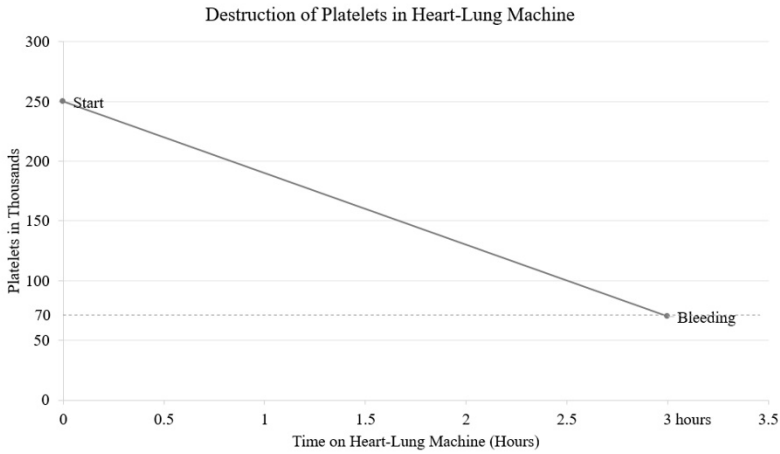
Dr. Penner was very pleased and immediately took measures on all elective open-heart surgeries to have autologous platelet packs (of the patient's own blood) prepared for each patient prior to the surgery and infused into the patient following the surgery. The patient thereby received his or her own healthy, undamaged platelets following the surgery. This transfusion worked and stopped the previously inexplicable post-surgery bleeding.

I requested that we have a meeting of relevant principals of the hematology and the thoracic surgery departments. Dr. Penner agreed that was a good idea. Professors representing both departments were in attendance. I noted, when I was in the operating room, the surgeons did not even consider bringing in a hematology consultant to help, despite there being an inexplicable bleeding problem! I communicated my perception that there was an atmosphere with a hidden incompatibility between the "active" surgeons and the "contemplative" hematologists. I further explained that I thought this was an erroneous—and dangerous—attitude.

There was some thoughtful discussion among both parties, the conclusion of which was that, going forward, whenever open heart surgery was scheduled, standard procedure would always include a hematologist on-call as a member of the team.

That was the last interaction I had with Dr. Penner. I was very interested in the publication of the research. However, I soon entered my internship at Boston City Hospital and, being swamped with a new intensity of work, Dr. Penner and I lost contact. (I believe he did eventually publish this work: COON WW, PENNER JA. POSTOPERATIVE BLEEDING: IDENTIFICATION OF CAUSES AND MANAGEMENT. Med Bull (Ann Arbor). 1965 Mar-Apr;31:62-6. PMID: 14266759.)

For my part, I considered my work on this service and collaboration with Dr. Penner to be a valuable and humanitarian success for all involved.



The relationship we found between platelets, time on the heart-lung machine, and bleeding

Lessons Learned

1. When there is a recurrent fatal result and traditional remedies are not solving the problem, do not hesitate to conceptualize other solutions—even in another specialty or profession—and pursue your insight with the guidance of an expert and whatever other resources you need to prove the validity of your hypothesis.
2. Be alert to prejudicial attitudes of some specialties and professions who may avoid consultation with less prestigious specialties and professions.

Chapter 6

Working in the Environment of an Army Field Hospital

In July, 1962 I left the University of Michigan Medical School and its University Hospital and started my internship in internal medical at Boston City Hospital in the city's South End. At the time this was a famed hospital that had training programs affiliated with the three different Boston-based medical schools: Harvard, Tufts, and Boston University. As a municipal institution, the hospital opened in 1864 to provide much-needed health care to both the urban poor of Boston and the ever-increasing number of Irish Immigrants entering the city during the mid-19th century. The hospital merged with the Boston University Medical Center in 1996, forming the Boston Medical Center.

At this time, the neighborhood in which the hospital was located was in decline, an area with an impoverished population as well as vagrants and alcoholics. I was living in Brookline, an upper middle-class suburb, traveling every other day to the hospital by public transportation. I was warned to be sure to wear my full white doctor's outfit and to hover near the street—away from alleyways—to avoid being mugged.

The value of the hospital to a new doctor-in-training was that there was a wonderful duality of having both a faculty of teachers who were superb as well as a great deal of individual responsibility given to the new doctors that thereby produced a superb experience that prepared them well for their future careers. In addition, most interns and residents of the hospital were from the feeding medical schools and represented the cream of the crop of new doctors, who were then assured of excellent placements in their next round of medical training or staff positions.

As it turns out, I was assigned to the Emergency Room as my very first "rotation." This meant I was the first physician who saw and evaluated a new patient. This was somewhat intimidating for a graduate of a medical school in a small town where patients were admitted as referrals from outlying hospitals, and were chronic, complicated cases, and certainly not anything urgent or acute.

The contrast from the quiet, elite, peaceful University Hospital in Ann Arbor, Michigan to the rash of off-the-street human victims of poverty, alcoholism, and violence was stunning. It felt like what I would have imagined a field army hospital to be like.

For example, my very first patient was a large, black woman in her mid-thirties who the nurse led me to, lying on a stretcher in an examining room. There was no history given. She had come in from off the street. And the first thing I did—in my orderly procedure that I learned as a medical student—was go to wrap her right arm with a sphygmomanometer cuff to take her blood pressure. Only as I experienced difficulty placing the cuff because of hard obstacles in her tissue did I look closely at her arm—there were several bullets lodged in her arm! (They didn't teach me about this in Ann Arbor.) Being a practical young doctor, with common sense, I then placed that same cuff around her left arm, sure that that would work. Bullets again!!! I then exclaimed to the nurse, "Get me an 18 gauge needle immediately!" "This patient needs an immediate Intravenous placed in her vein, and we should cross and type for blood, which she will also probably need."

This was my initiation to Boston City Hospital. The intravenous line was set, and the blood obtained. And it was clear that the patient, now stabilized, needed to go to surgery immediately.

This was the beginning of my experience at what felt to me like a "field army hospital."

In fact, a few weeks later, a patient came to the emergency room, with a chief complaint, of "an ear ache." I entered the examining room and asked, "How long have you had an ear ache?"

"For about three weeks,", he answered.

"What happened three weeks ago?"

"Three weeks ago, I was depressed, so I took my .22 caliber revolver, pointed it into my left ear, and shot myself," he said. "And now it hurts like hell!"

This was a routine "City Hospital" case. We got a skull film and, sure enough, there was his .22 caliber bullet, lodged in the petrous ridge of the temporal bone. I don't to this day recall exactly what I said to him. Perhaps, "Don't do that in your right ear..."

But these are just an introduction to my main story where my conduct as a physician was tested in a different way.

One day five white policemen brought in a young, black youth about 19 years old and they asked that I exam him. They didn't offer why they wanted me to exam him, but I hesitated to ask because the youth looked healthy, with no hints of anything wrong that I could see at a glance. I suspected that the police may have abused him, and they were just checking to see if he was injured. As the five policemen stood inside the room with me, the youth taunted them with a comment that I couldn't distinguish. Within the blink of an eye, the five policemen grabbed the youth, pulled him off the table, and threw him to the floor. With my patient's back on the floor, four policemen held his for limbs down and a fifth stomped on his genital area. Without delay—and despite the fact that I stood 5'4" and was of slender build—I grabbed the tunic of the policeman who had stomped on my patient before my eyes, took the number down on his badge, and said to him, "You are finished." This resulted in a sudden quiet in the room. No one said a word. With that statement having caused sudden peace in the room, I walked the 50 yards down the hall to consult with my superior, the physician in charge for the day. Hearing what had happened, he said to me, "Dick , if you report him, they will kill you." I was a bit stunned by this statement, but it only verified my sense of the corruption of the Boston Police Department in those days.

Nevertheless, I proceeded to do what I thought was necessary and important in regard to imperative ethics. I went back to the examining room and requested that the policeman who abused my patient come with me. I took him into another examining room and closed the door, had him sit down, and I sat down opposite him. To my surprise, this "killer-to-be" began to weep and beg me to not report him. He explained he had a wife and two children and his entire life would be ruined. I then told him what he did was profoundly out of line and unacceptable and represented serious abuse. I told him that if I ever hear of his abusing anyone again, I would testify at that time of what I saw that day. I admonished him to change his ways and protect his wife and family by never doing anything like this again.

I gave him time to compose himself and he left the emergency room.

By that time, other physicians had finished evaluating my patient who, judged not needing medical care, left the emergency room "in tow" of the remaining four police officers.

Lessons Learned

1. Expect the unexpected in an emergency room setting.
2. A physician cannot tolerate abuse of patients and must immediately work to stop such abuse.
3. If at all possible, the physician should attempt to prevent future abuse of patients.
4. Regardless of what line of work you are in, do not tolerate abusive behavior. Do something about it.

Chapter 7

The Diagnosis Made Only at Autopsy

During the spring of my year at Boston City Hospital, I spent one month as "Night Float" whereby I was responsible for two 30-bed wards from midnight to eight AM. I was totally alone and in charge throughout the night. My foremost task was to keep every patient alive. Period. My second most important task was to do a complete medical evaluation and treatment during the night of any patient who was admitted to the ward from the Emergency Room. The least important but required task was to draw all ordered blood samples for various tests on all sixty patients. All tasks were to be completed by eight AM, by which time I needed to be ready to present to the visiting senior physician the details of all significant clinical events that occurred throughout the night. On a normal night, after presenting to the senior physician at 8:00AM, I was off duty until that night at midnight. I would often go sailing on the Charles River at the Charles River Boat Club, have lunch, go to sleep at 3:00 PM, and arrive at the hospital close to midnight to take over for another night. But the story I will tell below was not of a normal night.

Shortly after midnight I received a call from the Emergency Room that they were sending me a patient in "diabetic

acidosis," a treatable but urgent medical condition found in diabetics whose illness is out of control. Usually, it is because they stop taking their insulin for one reason or another, although it can be due to an infection or other causes. The basic elements of treatment involves three things: (1) hydration of the patient with intravenous fluids; (2) electrolyte replacement to correct abnormal levels of sodium, potassium and chloride; and (3) giving proper insulin therapy.

By 1 AM "Thelma" arrived in the unit. I took a brief history and Thelma, a 45-year-old pleasant somewhat heavy woman with dark skin, told me that she was feeling so well a few months ago, she thought it would be okay to stop her insulin. Tonight, she got so sick that she realized, stopping her insulin wasn't such a good idea.

So, I went to work treating her acidosis, something with which I was very familiar after ten months on the job. An hour later she was stable and I turned my attention to doing a careful physical exam. During that exam I discovered something that was not only abnormal but unusual—something that I had never seen before and did not have the slightest understanding of what it was or its significance.

The finding was a hole in the patient's hard palate, the hard part of the upper part of her mouth. The hole was round, about the size of a half dollar. I noted nothing else about the hole that had any significance to me. . .no bleeding, no history of injury to it, it was just there—but it wasn't supposed to be there!

At about 3 AM I felt things were stable enough on the ward that I took some time off and went to have my dinner. Dinner was served at the house officer's mess in the basement; open

all night for the physicians and nursing staff who worked through the night.

The dining room was deserted except for one other physician seated and already eating. I took the chair opposite him and engaged in conversation. He told me he was a pathologist at the Mallory Institute of Pathology doing research all night across the street. After the usual pleasantries, I decided to query this pathology researcher at the famous institute about my strange finding in Thelma. After a bit of thought, the good doctor looked at me and said, "It could be cerebral mucormycosis." I asked him to describe this illness of which I had never heard. He told me it was usually diagnosed after death. But the hole in the hard palate of Thelma was consistent with what it does.

After dinner, not knowing what I was dealing with but serious about finding out—and realizing it was imperative to learn before 8:00 AM—I called Security in the hospital, spoke to the officer, and told him that I had an urgent requirement to spend the next few hours in the Medical Library which was closed and locked. He agreed and met me at the library a few minutes later and gave me entry.

From about 3:30 to 5:00 AM, I studied six textbooks of medicine. Each described mucormycosis, and each said it was only diagnosed at autopsy of the patient.

I found one article more recent than the books, published in the past year or so, which described that there were 12 cases—and 8 successful cures—known in the world where mucormycosis was diagnosed before death. None were in Massachusetts.

The descriptions of the illness were all compatible with the finding of Thelma's hole in her palate. Mucormycosis is a fungus that attacks a patient who is debilitated from another disease, as Thelma was with diabetic acidosis. It enters the body, sometimes through the mouth. Once it begins growing into the arteries in the mouth region, it feasts on the mouth tissue, killing it, and causing something like the hole in Thelma's hard palate. Ultimately, it usually grows into the brain and kills the patient. I left the library convinced that there was a possibility that Thelma had mucormycosis, but I knew that a biopsy needed to be done of her tissue to confirm the diagnosis. If it turned out that she actually had the illness, there was an intra-venous medication which could be curative.

At 8:00 AM I presented to the senior physician on duty who supported my tentative diagnosis of Thelma and told me which Oral Surgeon I should consult as soon as possible to have the biopsy done.

Walking as fast as I could, I made my way through the building complex that made up Boston City Hospital. Finally, I found Professor Gerald Shklar, and made my case to him, explaining our urgent need for the tissue diagnosis. His response was immediate and curt: "The patient is too sick to biopsy," he said, "I will not do it." I was stunned. I peered at the Professor—me, the Intern, in my first year as a physician, standing before this esteemed Professor. Gathering myself together, I calmly replied, "I understand what you have said, and I do not agree that the patient is too sick to be biopsied or I wouldn't have made the request. But I will say to you that, I am going forthwith to the

ward and I am going to write in the patient's chart, that you refused my request of a potentially lifesaving biopsy, required to treat the patient of that which may be an otherwise fatal illness." After leaving his office, it took about 8 minutes to arrive back at the ward. As I approached the nursing station the phone was ringing. One of my colleagues answered and handed me the phone, "It's for you," he said. It was Professor Gerald Shklar. "I will do it," he said.

By the end of the day we got word that the patient had mucormysosis. The news spread rapidly throughout the hospital, that this rare illness—never previously diagnosed prior to death at the famous Boston City Hospital—was diagnosed in a living patient, a patient who could be cured.

I was removed of all duties to do nothing but treat this patient. I ordered the intravenous Amphotericin-B and started the treatment that night. It required daily, slow infusions lasting 2 to 6 hours. The medicine caused the veins to sclerose such that every couple of days the vein I was using for the infusion failed and I had to find another to continue the treatment. Importantly, however, the hole in her hard pallet stopped growing larger.

There was, simultaneously, a great deal of excitement in the hospital that this illness had been diagnosed—not only was it the first in the history of the hospital but also the first in the history of Massachusetts medicine.

The hospital held an "all-hospital" Grand Rounds with people "hanging on the rafters" where I presented the entire case. There was a standing ovation at the end of the presentation. Then there was another Grand Rounds, this time in neurology and chaired by the world-famous neurologist Derek Denny

Brown. I was sitting in the back of the auditorium and Professor Brown started to speak, hesitated, and looked up. He saw me sitting in the back and said, "Dr. Budson, you know so much about this, and I so little, could you please come forward and address us?" There was a startled murmuring among the neurologists all around me. "He's never done this before," they whispered.

After six weeks on amphotericin-B, the patient was cured and discharged.

Six months later I received a call from a restorative dentist who was repairing her mouth who told me that she was, by then, totally rehabilitated.

Mucormycosis of the Oral Mucosa

RICHARD TAYLOR, DMD
GERALD SHKLAR, DDS
RICHARD BUDSON, MD
AND
ROBERT HACKETT, DMD
BOSTON

A case of mucormycosis essentially localized to the mucosa of the palate and contiguous tissues has been reported in a 40-year-old diabetic female. Palatal bone had undergone necrosis, and maxillary sinus mucosa was also involved with lesions of mucormycosis. Diagnosis was carried out by culture of the organism and by microscopic studies utilizing appropriate staining techniques. Successful therapy was effected by the use of amphotericin B and regulation of the diabetic state. Negative biopsy was used as a measure for success of the therapy employed.

Mucormycosis is a rare mycotic infection of man, but it has appeared with increasing at autopsy. The mycotic organisms involved belong to the order of mucorales of the class phycomycetes and are common inhabitants of soil and decaying vegetable matter. The mycelia of the mucorales consist of wide, branching, nonsegmented hyphae. The fungus can be seen in hematoxylin-eosin stained tissue specimens, but it is more clearly outlined using the periodic acid-Schiff technique for mucopolysaccharides.

Spores are not commonly seen in tissue specimens. These fungi grow well on Sabouraud's medium, and the spores can be clearly demonstrated from these cultures. Morphologic differences in sexual and asexual spores as well as in other features serve

Our published paper


Boston, June 30 1963

This certifies that Richard David Budson, M.D.

has faithfully served Fifth and Sixth Medical Services

Boston City Hospital,

Intern

July 1, 1962 to June 30, 1963

Lessons Learned

1. Always perform a careful physical examination—you just might make the critical diagnosis!
2. Just because a patient comes in for one problem doesn't mean they don't have another—perhaps more serious—problem.
3. When you discover an unusual finding that you don't understand, work to understand it.
4. Don't be shy about asking anyone for help so that you can understand what is wrong with your patient.
5. When you encounter a disorder that you don't know in one of your patients, read about it as soon as possible.
6. If you need knowledge in the middle of the night, get it.

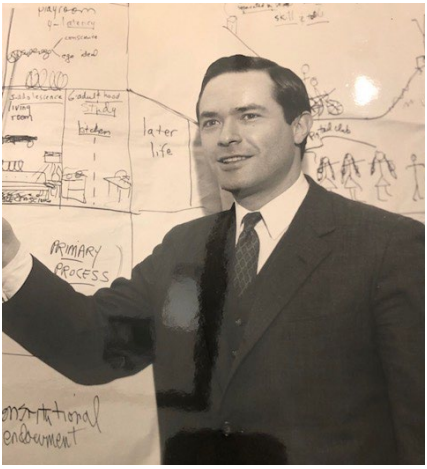
7. If you are considering an unusual diagnosis, study up on it so your opinion is based on solid ground.
8. If you're sure your right about a diagnosis, make a compelling case to the physician-in-charge.
9. If a specialist refuses to see a patient, document this clearly in the chart—it will come out at the patient's autopsy.
10. In brief, do what you need to do to save your patient's life.

Chapter 8

The Beginning of a Revolution

I had many opportunities after my internship to go to different training programs in psychiatry throughout the country, partly as a result of the recognition I received regarding my work with Clara in the state mental hospital while I was a Harvard undergraduate. But I chose to stay in the Boston area and go to the McLean Hospital in Belmont, Massachusetts. McLean had a sterling reputation as a private psychiatric hospital and is still today in the top rankings nationally. At the time I began my training there, McLean was a Harvard Medical School teaching hospital and a division of the Massachusetts General Hospital. Originally named the Asylum for the Insane, it was organized in 1811 by a group of prominent Bostonians who were concerned about homeless mentally ill persons "abounding on the streets and byways in and about Boston". The original hospital was built around a Charles Bulfinch mansion in a section of Charlestown that is now a part of Somerville, Massachusetts. The institution was later given the name The McLean Asylum for the Insane in honor of one of the earliest benefactors, John McLean. In 1895 the hospital was moved to a campus in Waverly Oaks Hill in Belmont, Massachusetts. Frederick Law Olmstead (the renowned landscape architect) was consulted regarding its new site. (Olmstead himself eventually was treated at McLean.)

McLean through the years had become a quiet, elegant retreat for the mentally disturbed of the upper classes of Boston. In fact, a common quip about the hospital was that, "A proper Boston Brahmin, was a Harvard Graduate who lived in a home on Commonwealth Avenue and had an Aunt who was at McLean."



As a post-residency fellow, teaching at Beth Israel Hospital, Boston

In my first few years at McLean, I experienced it as a self-consciously elitist hospital, proud of its Harvard Medical School connections, overly impressed with the work of Sigmund Freud, and very much attached to the idea of intense, thorough, and very long evaluations. My impressions were that these evaluations not infrequently "missed the point," and hospitalizations often lengthened from six months to a year or two. I believed that such long evaluations created an environment for patients to which they became accustomed to being obedient to the staff, taking on the identity of a "good patient," with little vision of a future role in the community.

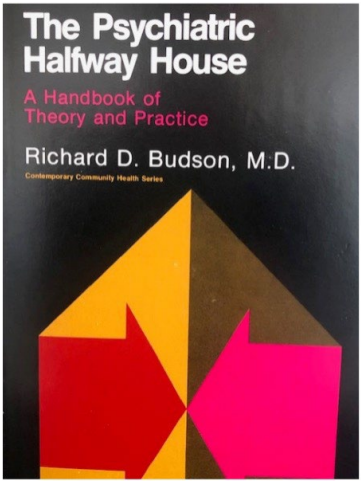
As the reader has seen in Chapter 2, I had the experience during my college days of engaging a psychotic patient in the hospital environment of the impoverished, state mental hospital. And, after my early years at McLean—the elegant up-scale private mental hospital of the affluent—I realized the similar

shortcoming of both public and private institutions. At this time, I conceptualized the need for a genuine, in-the-community, residence for the recovering mentally ill—be they affluent or impoverished—where they learned the skills of life in the community, instead of obedience to a condescending staff. I spent the next 35 years of my career developing a community residential care system for McLean Hospital, which changed the hospital from a 300-bed inpatient psychiatric hospital to a 160-bed inpatient psychiatric hospital with an additional 178 community beds in 14 programs throughout Boston and near-by suburbs, staffed by "house managers" instead of nurses. It had a $19 million budget.

McLean Hospital, Belmont, Massachusetts

I was simultaneously contacted by Massachusetts Mental Health Commissioner, Milton Greenblatt, MD—the same psychiatrist who engaged me and spoke about my work at Metropolitan State Mental Hospital ten years earlier when he was Director of Research at the Massachusetts Mental Health Center. He had heard that I was starting so-called "halfway houses" for McLean Hospital, and asked me if I would, at the same time, start up the Massachusetts state halfway-house program. This required me to meet with the State Attorney General, who wrote a special ruling so that I could do both programs. This opportunity led to my starting 110 additional halfway houses for the Commonwealth of Massachusetts.

I conceptualized—and actuated—a real "revolution" in the delivery of mental health care in Massachusetts at both one of the nation's foremost psychiatric hospitals as well as the mental health system throughout the state. This change required the conceptualization and actuation of a whole series of new ideas and entities that changed both the site and the function of caring for large numbers of people, formally addressed as mental patients. This change required education of the mental health professionals to think in more practical ways about the needs of their patients. It required a new mindset for them. They had to help patients think about what education and work they might do in the future, instead of incessant thinking about "their mother's words and ill deeds" in the past. In addition, the residential facilities were also a new kind of licensed facility, based on being "homelike," but still requiring operating authority, building codes, zoning regulations, and a conceptual home-base that described the ideation of the revolution.



In my book, "The Psychiatric Halfway House: A Handbook of Theory and Practice" (University of Pittsburgh Press, 1978), I outlined the essential differences and attributes of the community halfway house versus the hospital, as follows:

There was a desire to alleviate four basic deficiencies of the traditional large institution.

Largeness: The traditional state mental hospital housed at least 1000 patients, with groups of up to 60 on a ward. Because of inadequate resources, functional staff frequently consisted of a single ward nurse or attendant who could do little but maintain order and attempt to meet the most basic needs of the patients. This situation contributed to what has been described as the "social breakdown syndrome"—a social withdrawal caused by the loss of meaningful interpersonal exchange leading to increased retreat into a patient's inner world.

Universal Medical Model: The patient was considered sick 24 hours a day, reinforcing their self-image as defective and helplessly dependent on the hospital staff. The patient-nurse relationship was one where the patient was a passive recipient from an active embodiment and purveyor of health. Little distinction was made between acute psychotic episodes and periods of diminished symptomatology. The patient was considered "sick" around the clock. Healthy functions were

disregarded, as the very identity of the professional staff depended upon a focus on the patient's pathology. Even activities providing a variety of living experiences in the hospital were identified as occupational, recreational, music or art "therapies." In short, the hospital was a place to be "sick."

A Closed Society: Like other closed social systems (the military, prisons, and religious orders, for example) the psychiatric hospital had its own unique social order, with its own rules and codes of punishment for transgressions. Attendants decided whether a patient went into seclusion or was allowed privileges on the grounds. The code of acceptable behavior varied from staff member to staff member. Frightened, compliant patients inevitably became less willing to take initiatives toward health or any other life situation.

Isolation from the Community: Most psychiatric hospitals were separated from a community by rolling, manicured hills, or winding driveways. The physical isolation made interactions in a normal setting next to impossible for the patients.

In summary, the large impersonal ward, run on a universal medical model, imposing its own standards of conduct, in a remote hospital setting generally reinforced pathology and perpetuated the "patient" state.

By contrast, the psychiatric halfway house or community residence explicitly alleviates these four problems with the following attributes:

Smallness: Typically, the residence is a large old house or an existing lodging house with approximately 15 residents, located in a regular neighborhood so that the residents feel they

are members of a community. "House parents" live in the residence 24 hours a day. All decisions affecting the life of the house are routinely discussed as a group including the residents and the staff. Good friends are encouraged as a natural pathway to independent living whereby, in time, small groups of residents will leave, rent near-by in the neighborhood, and visit the home-base as members of a family would.

The Family Model: There is an attempt to re-create a sound, family-like living situation (also called a "family modeled social system"), where non-related people live together "as a family." The occupants are known as "residents" not "patients." The house managers live in the house as "parents" would, and one of the pair may work outside the home during the day. In house meetings, the house parents stress that "health is not the absence of problems, but rather is the ability to effectively deal with one's problems." Staff may equally participate with residents—sharing appropriately how they cope and deal with normal, everyday problems.

An Open Setting: The family group lives in a neighborhood to which it relates to in several ways. It shops for food there, attends religious services there, and takes advantage of recreational and entertainment facilities in the area. In its turn, the community residence accepts the mores of the neighborhood. Excessive noise, illicit drugs, and belligerent behavior are precluded by general community codes. Behavior is not determined by idiosyncrasies of the staff. Compliance with codes is therefore meaningfully related to successful living in the real world.

Integrated with the community: The goal is met by the residence in a normal community. The resident's trips to the market,

drugstore, bank, or theater challenge the resident, stimulating the person to a higher level of functioning and more adaptive modes of behavior.

These four attributes of the psychiatric halfway house—as a small, family-like domicile naturally open to the mores of the community and located truly within it—provide a rich contrast to the stark environment of the traditional psychiatric hospital.

Setting up exhibit on Halfway House concept at American Psychiatric Conference, Dallas, Texas

Lessons Learned

1. Don't be afraid to create an entire new system of care when you can clearly see that it is needed for the best care of your patients.
2. When you do good, innovative work others will follow you.
3. Share what you have created with others through books and scientific papers.

Chapter 9

Threat to the Revolution and its Successful Management

Now that the reader has an understanding of the value and essence of a community residence versus the shortcomings of a psychiatric hospital for rehabilitating patients/residents, we dial back to understanding that my task, given this ideology, was to start the McLean Hospital system of halfway houses, learn from its beginning, confirming and validating its therapeutic concepts, and following up with the simultaneous development of the McLean and state systems. I also understood clearly that this was to be a new legal modality of treating psychiatric patients—although designated "residents"—that would require legitimate licensing of each program, creating of a building code for housing and zoning standards. That I was working both for the Harvard and state programs facilitated my work, with the state blessing my efforts. However, right from the "gate" in my race to get this done, I was startled to learn of an effort, heretofore unknown to me, that could have sabotaged the entire program.

Just as I was starting the serious business of purchasing a $300,000 building on Marlborough Street—a historic 5-story townhouse suitable for housing 23 residents in the Back Bay of Boston—to start our first program, I discovered that a Professor Gunar Dybwad at Brandeis University had been working with

Governor Sargent to come out with a universal law affecting all halfway houses, limiting them to only eight residents. Professor Dybwad was a specialist in patients with developmental disabilities and he was focused solely on the size of program that would best serve that group clinically, without any consideration of any other clinical group, nor of the budget of the program, size of staff etc. It was instantly apparent to me that such a law would completely prohibit the rehabilitative programs I was planning for the mentally ill, as the limitation to such a small number of residents would prohibit sufficient revenue for a truly rehabilitative staff.

Thus, I had my first challenge with "authority" in this venture, and the authority was none other than Governor Francis Sargent of Massachusetts.

Massachusetts State House

I called the Governor's office, explaining that I had to talk to the correct person about a pending piece of legislation. I was referred to the governor's Legislative Assistant, Elton Klibanoff. Within a few minutes I had an appointment secured the following Wednesday at 11:00 AM. I arrived on time at the State Capital and discovered that Mr. Klibinoff's office was next door to the Governor's. This proximity immediately impressed me. Mr. Klibinoff was cordial, kindly, and very smart. I learned later that he earned a Bachelor of Arts Degree with Distinction in History from Brown University and a Juris Doctor Degree from Harvard Law School. In researching him for this book, I found it not insignificant that he had authored the book, For the Survival of Liberty: Great Presidential Decisions.

After the pleasantries were exchanged, I explained to him that I respected the work of Professor Gunar Dybwad on the Developmentally Disabled, and that I was sure he was well intended in his position that halfway houses should be no larger than eight residents. I told him that size may be best for the developmentally disabled, but the case is very different for the mentally ill. I asked him if his intention was to have this bill be applicable to halfway houses for all kinds of disabilities. It turns out that wasn't actually his intention but, inadvertently, that is what the status was at that moment. Fortunately, the bill was only in draft preparation at the time. I explained to him that with the young adults in post-psychiatric hospitalization recovery social connections, the making of friends, with whom they can eventually move out into the community after the halfway house, was a major goal. And to achieve that goal developing friends, there needed to be an adequate mass of residents where

there is a greater likelihood of "a match." I explained that the McLean Hospital was about to invest $300,000 in a townhouse on Marlborough Street that is for 23 residents where we will have a fulltime staff of a married couple both of whom have MSWs, and that with only 8 residents we could neither meet our clinical goals nor pay for the program because the income wouldn't be sufficient to make the payroll. We went back and forth and, as the hour was approaching noon, Mr. Klebinoff suggested we continue our discussion over lunch at the Parker House Hotel, directly across the street from the State Capitol.

President of the State Council chatting with a colleague.

We resumed our discussion at lunch, thoughtfully throwing this and that idea to each other, during which I began to feel I was finally getting somewhere with him. Although he declined dessert, I ordered some ice cream. As I put the first spoonful in my mouth, Mr. Klibinoff bent over to the floor under his chair and briskly pulled out a yellow legal pad and pen. To my shock and amazement, he then looked at me and said, "Okay Dick, tell me exactly how *you* would write this bill." And I proceeded to tell him about ten items: "I would start with this... . and then I would say that... . etc." By the time I concluded, I was done with dessert and the bill was drafted!! Mr. Klibinoff said, "Let's go back to the State House." As we were walking across the

street toward the State House, he said, "Let's go into the lower level of the State House to the Linotype Room." I followed him into the labyrinth of corridors until we reached a large horizontal opening in the wall, with a long desk-like surface and several technicians "at your service" with complicated printing machinery visible in the back layers of the large room. Mr. Klebinoff extended his arm, moving the yellow pad from his hand into the hands of the linotype technician and said, "Make this into law."

And so it became the law of the land.

The revolution could continue unchecked. I confess I was shocked that my comments, stated as thoughtfully as I could over dessert in the Parker House, could "presto" became law. But they did. And I had accomplished securing a sound legal basis for the psychiatric halfway house in the Commonwealth of Massachusetts. Although there was more work to do, I had my first legislative success and was ready to tackle the next.

Interior of Massachusetts State House

Lessons Learned

1. Don't be afraid to engage power and authority when you have a good case that will protect your patients.
2. Engage those involved not with argument nor rancor, but with collegiality and cordiality.
3. Work tirelessly to achieve a win/win in all disputes.

Chapter 10

In Pursuit of a Unique Building Code

To create family-modeled halfway houses in bustling active neighborhoods near shopping, entertainment, and recreation, the last thing we needed was an institutional building code with sprinklers and steel and concrete construction. What would the Massachusetts Building Code Commission say? We were worried that if we suggested a unique residential-style code for our programs, they would find our request to be outlandish, pie-in-the-sky, and irresponsible daydreaming. But we were sure that if we had to comply with a typical institutional building code that all our aspirations were finished. Such buildings would usually have to be built from scratch and we knew they either wouldn't be affordable to construct or wouldn't be found in neighborhoods compatible with the goals of our program. So, the onus was on us to convince the Building Code Commission that we could come up with a system that would assure the residents would be safe without an institutional code.

We started our own research and soon found published opinions that sprinkler systems were great for keeping buildings from burning down—but not great for saving lives, because people die of smoke inhalation. Given that, we knew we had to come

up with an alternative system. So, we developed a multifactorial, common-sense fire safety system involving 5 elements:

1) The resident would be tested to confirm their capacity to sense physical danger, to judge when that danger requires immediate egress from the building, and the capacity to learn and execute two means of egress.
2) The building would have two entirely separate means of egress from all parts of the structure, including the bedrooms.
3) A heat and smoke detector system hardwired throughout the facility would be installed.
4) Each resident and staff living in the dwelling would be required to pass a test showing they were able to egress in two different routes within 2 ½ minutes from the sound of the alarm.
5) The entire hardwired heat and smoke detector system would be directly connected to the nearest fire station.

This system was our best concept of what would be safe—and actually doable—in existing buildings in the neighborhoods that would benefit the life of the residents. So, with "hat in hand," I went to meet with the Massachusetts Building Code Commission, located in one of the state office buildings. The meeting was at 11:00 AM. The entire Commission was present, including 20 members plus the Commissioner, Raymond Caravaty, who was also Professor of Architecture at Rensselaer Polytechnic Institute.

With all available earnestness, I presented the entire argument stated above for a unique building code for our residences. The Commission listened politely and quietly. When

I finished, there was unexpected applause. One of the Commissioners then arose and said that this had never happened before in this way; they found it uncanny that Mr. Caravaty, the Commissioner, had made an identical presentation to the Commission in the previous hour. We were not only in entire agreement but, down to the last detail, we came about the solution to the problem in the same way.

I was at the time writing my book on the halfway house (as noted in Chapter 8), and the reader may turn to page 100 in that book and see that Raymond Caravaty's name is on the related chapter because, on the spot, I invited him to coauthor the chapter with me. He did, and together we submitted the code to the US Congress, which published it in the Congressional Record on April 23, 1979.

THE MCLEAN HOSPITAL
Belmont, Mass., April 23, 1979.

Hon. CLAUDE PEPPER,
Chairman, Select Committee on Aging,
Washington, D.C.

DEAR SIR: I hereby officially submit and request that Chapter 7, "A Group Residence Fire Safety Code," in The Psychiatric Halfway House: A Handbook of Theory and Practice, authored by myself and published by the University of Pittsburgh Press, be included in the Hearing Record held on April 25, 1979. This chapter outlines a successful fire safety code for group residential care for the mentally ill. It is a model for the nation.

Additionally, I enclose a short paper for the Community Mental Health Journal entitled "Legal Dimensions of the Psychiatric Halfway House," which makes reference to the building code described in detail in the book.

I continue to be available to you and your staff for consultation.

Sincerely yours,

RICHARD D. BUDSON, M.D.

LEGAL DIMENSIONS OF THE PSYCHIATRIC HALFWAY HOUSE

Richard D. Budson, M.D.

The psychiatric community residence or halfway house has been described extensively in the psychiatric literature from a programmatic point of view (Budson, 1973; Glasscote, Gudeman, & Elpers, 1971; Landy & Greenblatt, 1965; Raush & Raush, 1968; Rothwell & Doniger, 1966). Their numbers have grown from 7 in the United States (Wechsler, 1960) in 1960 to 148 (Glasscote, Gudeman, & Elpers, 1971) in mid-1969. In Massachusetts alone, by mid-1973, there were over 100 community residences for the mentally ill and retarded. As these programs become more numerous, a clear legal definition of them becomes increasingly essential as local communities, state legislatures, and national standard setting bodies respond to their increasing presence.

This paper addresses itself to the solutions developed in Massachusetts to three

A Group Residence Fire Safety Code

(With Raymond Caravaty)

Like any other building, the halfway house must conform to the building code of its community. This is necessary to protect both the health and safety of the residents, as well as to ensure that the residence acts as a responsible member of its community. However, the building code should not require the community residence to sacrifice its ideology and goals.

The need for a specific building code for community residences is based on the fact that community residences are neither institutions nor lodging houses. Strict institutional codes inhibit creation of a homelike milieu, and the safety regulations required for lodging houses are often inappropriate to the community residence, where people know and care for each other, live in a more organized manner, eat together, and share chores. The state or local community should therefore develop a building code that takes into consideration both the programmatic ideology of a community residence and safety factors relating directly to halfway houses.

Lessons Learned

1. Work hard at conceptualizing and mastering whatever you are doing, even if something completely new. If you are thoughtful about how it should be done and you "really know your stuff," you just may find that the experts are in complete agreement with you.

Chapter 11

Using the Power of the Press to Challenge Potential Litigation —re: a Zoning Issue

Curiously, while writing this work, I almost forgot that I published an op-ed piece in the Boston Globe on May 4, 1982, that relates to what we are talking about today. "Why did I almost forget?" The answer was because I didn't engage with people in my encounter with the problem, nor with my solution. Rather, it was uniquely expressed through journalism. I wasn't called on the phone about it, nor did someone speak to me about it in person; I read about it in the newspaper.

The issue that I read about in the newspaper was whether a psychiatric community residence could require a disruptive resident to leave on clinical grounds alone—without the legal eviction process that would typically be triggered if a landlord tried to evict a tenant. Most community residences, as therapeutic living environments, differ from typical apartments because of the contract which individuals agree to at the outset: They are there to work at developing their life skills, and the clinical staff are there to support and help the residents. It is understood—and in the contract—that if the resident behaves in ways detrimental to themselves or the program, they may be required to leave.

The specifics were that a woman was required to vacate her place in a "shared apartment" supervised by the Lindemann Mental

Health Center in Boston because of disruptive behavior. Her behavior created an atmosphere that interfered with the mental wellbeing of the other resident occupants. She then filed suit in Boston Housing Court in an attempt to obtain a temporary restraining order that would have allowed her to return to the residence.

I was alarmed and perturbed that if clinically supervised halfway houses for rehabilitation of the mentally ill lost control of who had jurisdiction of who lived there, the entire state program could be doomed. I immediately recognized that, because this issue was being played out through the readers of The Boston Globe, the best way for me to respond was also through The Boston Globe. Reports that there were considerations to appeal the case to the U.S. District Court made it imperative that I preemptively draft my opinion in the newspaper—which touched all stakeholders concerned at once—before it got to court.

Then the task was simply to wait and see. Would my article be a sufficient deterrent? Perhaps part of the reason I didn't think about this chapter of my life for this book was that there was "no applause" or any other outward affirmation of success. All that happened was, "nothing." Subsequent to the publication of the op-ed (see image) there was no subsequent legal action taken involving this issue. I believe that by clarifying the pertinent facts and issues of concern to the various stakeholders, I calmed them down and they saw there was nothing to be alarmed about. The halfway houses and other community residential programs were relieved from the concern that there would be a long, dragged out disruptive legal battle that would be destructive to the overriding efforts to create humane, caring community environments to help bring the mentally ill to health.

THE BOSTON GLOBE Tuesday, May 4, 1982

Evicting the mentally ill

Community residential care for the mentally ill is uniquely subject to legal and ethical problems which have no easy solution. This is due to its ambiguous position between public housing and health-care facility. The problem of patients rights arises, in particular, when a disruptive client is asked to leave such a residence.

A case was described recently in which a woman was forced to vacate her place in a "shared apartment managed by the Lindemann Mental Health Center in Boston." Apparently the management considered her to be disruptive to the program. The client then filed suit in Boston Housing Court in an unsuccessful attempt to obtain a temporary restraining order that would have allowed her to return to the residence.

The case was argued over the issue of whether or not program residents were "entitled to landlord-tenant protections"—such as requiring legal eviction proceedings to remove such a tenant. The case purportedly will be contested by means of a class action suit to be filed in US District Court.

Cannot a residence if it is a Nonprofit service agency, require a disruptive patient to leave solely on clinical considerations without having to go through formal eviction proceedings rather than a clinical intervention would, by taking power from the clinician and giving it to the courts, be somehow more in the overall interest of the client.

However, there is certainly no guarantee that such a legal proceeding would do anything constructive whatsoever for the disruptive client, who would likely be evicted anyway.

Further, eviction would surely pit the caregivers against the client intruding on their basic wish to help find alternative housing, in spite of the difficulties. Nor should it be ignored that a seriously disruptive client remaining in a residence during legal proceedings may abuse abuse the rights of other clients who possibly would have to live in constant fear.

Two key issues must be addressed in considering this question. First, even though a patient may not be commitable, that doesn't mean he doesn't have significant mental disorder. Even though this disorder may not lawfully justify the taking away of his rights, that same degree of pathology may significantly intrude on

the rights of others, making his continuing stay in the residence untenable if the residence is to continue effectively serving anyone else.

This brings us to a second issue. It is not an inherent right to live in a community residence. A community residence cannot be regarded as providing only housing. It also is a therapeutic community with trained staff providing a carefully developed program of care designed to facilitate patient growth and health.

A disruptive consumer does not have the right to remain in a residence if he is unable to utilize the services it is designed to give. However, if the residence can require a person who has refused treatment to leave on clinical grounds where he would go is unclear and another dilemma.

This is a growing pain of a new mental health system in evolution. The solution to this problem will have to be developed through thoughtful efforts of the patients themselves, the service providers and the state agencies, taking into account the respective rights of all the players upon a complicated stage—includlilng the disruptive patient, the larger body of patients, the staff of the program, and the community at large.

It is important that no single solution be prematurely espoused for so complex a system. Insisting that disruptive residents can only be removed from these mental health programs through eviction proceedings can lead to chaos in the program which may only strengthen the arguments of those who would have all the patients return to the institutions anyway.

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Lessons Learned

1. The judicious use of an article written for the local press can have important substantive effectiveness in the clarification and solution of vital public issues.
2. It is important to be ready to advocate for important issues in whichever venue is appropriate, whether that be via newspaper, radio, television, social media, or in person.

Chapter 12

A Collaborative Effort

When I think about and consider all of the events described in this book, what is surprising and wonderful isn't at all what I did, but rather what the other people did in response to my initiatives. They were receptive to my engagement. Even the policeman who I threatened because he was abusive didn't attack or assault me. Instead, he engaged me in considering how his loved ones, his wife and his children, would be destroyed if he lost his profession and his job. He wept before me and begged me to give him a chance. He mounted the higher side of the issue and—along with my urging—moved toward reform. Similarly, the oral surgeon who I told would be quoted in the medical record as not willing to do a life-saving biopsy for my patient to confirm her diagnosis of mucormycosis that would be visible after her death, didn't berate me after he reconsidered and performed the biopsy (confirming her life-saving diagnosis), he phoned me after her successful treatment, asked me to help him write the publication, and named me an author in it. The multitude of high school students in Detroit—among whom there were gangs frequently engaging racial fights at the football games—didn't challenge the authority our all-city student council, they negotiated stopping the fights. Peace, not war, reigned, and concluded with a visible and palpable camaraderie in our

"Play Day," inter-racial picnic on Balle Isle. The surgeons who were stymied when there was fatal uncontrollable bleeding several hours after closing apparently successful open-heart surgery accepted the solution I created with grace, and ultimately concurred with my suggestion that there be a routine on-call hematologist whenever there was an open-heart surgical case. It was quite remarkable that, when I was summoned by the Professors of Physiology to inquire about my class top final exam that included far more information that they had taught (and I essentially gave a critical review of their shallow and tepid effort in their course that I felt was inadequate and not up to the requirement for new physicians), they didn't respond with the slightest negativity, but rather thanked me for my comments and congratulated me on my effort.

When I approached these various parties in my efforts, engaging them in search of truth, of peace, of life, of healing, of human dignity, and of betterment of learning, I found that their better sides were stimulated. Each and every one of them joined me in a collaborative effort toward mutuality in the betterment of the situation.

Challenging authority shouldn't be done lightly. It should be done in a circumstance where there is something amiss, not right, dangerous, or even life threatening. Or, if not dangerous, the issue must be important enough such that if it isn't "up to snuff," it requires serious rectification.

In some of these instances, there was a routine gone awry that needed to be fixed. In others, over time, the validity of the status quo gradually, almost imperceptibly, deteriorated. Sometimes it was the refrain that it has "always been done that way,"

without regard for the new realities. The commonality is that in each case something desperately, urgently, needed to be done.

The successful challenger also has defining characteristics. He or she is perceptive, smart, self-confident, well spoken, knowledgeable, and has "a way with people." Taken together, these characteristics help those challenged to feel comfortable with what is happening, aware that the status quo is being changed into something better. The successful challenger is insightful, meticulous, and thorough. She or he is not impulsive, but rather systematic and methodical. This insightful, meticulous, thorough, systematic, and methodical approach leads to a deep understanding of the issue such that the precise concept invoking the change is impeccable, so correct, that it is virtually non-contestable. Challengers have done their homework, researched the issue, and evaluated their stakeholders so their conclusion is not only irrefutable but acceptable. It is the precise truth, as in a court of law: "*res ipsa loquitur*," which means, "the thing speaks for itself." When the truth is impeccable, it is also calming. There is nothing to argue about. The consensus can be quietly reached, and the result is harmony instead of discord.

The chapters in this book illustrate these tenets. They are examples of benefit to all in the service of the truth brought to bear by the challenger in a smooth, peaceful manner.

About the Author

Dr. Richard Budson has extensive experience as a healthcare professional, hospital executive, public policy planner, author, political consultant, and financial negotiator. Dr. Budson had a 35-year medical career as an associate professor at Harvard Medical School and a clinical director of McLean Hospital, a division of the Massachusetts General Hospital. He has also been adjunct professor of public policy, Georgetown Institute of Public Policy, Georgetown University. Dr. Budson pioneered the development of community care for the mentally ill. His seminal book, "The Psychiatric Halfway House: A Handbook of Theory and Practice," University of Pittsburgh Press, 1978, was translated into Japanese by order of the National Institute of Health of Japan and was cited as one of the 10 best university press books of the year by the NYTimes Book Review. During his tenure at Harvard, he developed a 178-bed program in 14 sites in the community for rehabilitating patients, and simultaneously was in charge of the state program in the Commonwealth of Massachusetts developing an additional 110 halfway houses. He consulted to four succeeding governors of Massachusetts. After retiring from Harvard Medical School, Dr. Budson was consultant to Washington, DC Mayor Anthony A. Williams, and was Chairperson, State Mental Health Planning Council of the District of Columbia. In 2001 the National Association of Social Workers awarded him "Public Citizen of the Year" for dedicated service. Dr. Budson was

the guest of first lady Rosalynn Carter at the White House, appeared on ABC News "The Reasoner Report," and was listed in Who's Who in the East. Dr. Budson is a graduate of Harvard College and the University of Michigan Medical School. He interned at Boston City Hospital and subsequently trained at Harvard Medical School teaching hospitals before joining its faculty.