—Narcotics in Baltimore

(FROM PAGE ONE)

would collapse.

Like hunger for anything else, dope addiction is controlled by the mind.

A highly respected, worldwide society which proclaims and asserts the fact that the right mental conception can cure all the body's ills, asserts that a change of mind can immediately cure the dope addict.

At the same time, medical authorities agree unless the addict is willing to become cured and is determined within himself, no amount of medical treatment can be effective.

HEAL THYSELF

Therefore, help for the addict starts with himself.

A noted local physician once told the AFRO when he realized his death would leave his wife and small children alone in the world, he cured himself of cancer almost overnight.

He states, "I am sure dope addiction cure can come that way too.

"I was told by my fellow physicians that I had cancer. I tested myself and applied the knowledge I had from books. I had cancer.

"I sat alone by myself and thought it over. I did not want to leave my wife and I wanted to see my children grown up.

"I decided to deny the myth, that I had cancer. I decided not to accept it. I shut it out of my mind. I dwelt only on the thought that I was well, whole and strong and perfect, physically manifesting only my mental picture of perfect health.

"The next time I saw my fellow physicians, they asked me what happened. They said you look fine. What happened?"

A CHANGE OF MIND

How can a person otherwise change his mind about dope addiction? If he can not find strength to overcome it alone?

The answer is, seek psychological aid.

The same free treatment centers that perhaps will place the addict under medical treatment, can advise him who will help him turn his mind around and under his own power.

What about the pressures of today's society that may have caused the addict to seek to hide away in dope in the first place? Can a change of mind eliminate them?

The proper medical authorities will also give this advice. It is a part of the treatment.

EITHER THIS OR DEATH

Whatever the steps necessary to cure the addict, it is certain dope addiction if allowed to continue will surely consume the victim, one way or another, and the city, sooner or later.

The question comes, "Will you die, will you perish, will you destroy all mankind? Or will you take hold of yourself and be cured?

Baltimore has several drug abuse treatment centers funded either by the federal or city or state governments.

MCT

The Medical Coordinating Team, Inc., a non-profit coalition of drug abuse treatment agencies here has offices at 603 W. 30th St., with Dr. Terrey Brown, president, Grenville Whitman, vice-president and Sampson Green, secretary-treasurer.

Listed as members of MCT are representatives from the various drug abuse programs including Provident Hospital's Adapt Program, Hopkins Hospital Program; Northwest Drug Alert, Sinai Hospital; Neighborhood Young Adult and Adolescent Drug Abuse Program (Druid-Sinai); the Cherry Hill Program and Man Alive Research Inc.

The above programs are currently treating 1,400 narcotic addicts and other types of drug abusers through a variety of methods including detoxification, individual counseling, group therapy, therapeutic community and methadone maintenance.

MCT is not a treatment agency itself but aids in coordinating existing programs for maxium benefit to those in need.

The Medical Coordinating Team is involved in the following activities:

— coordination of efforts of the member programs. Toward this end, using a grant from the Emmett Davis-Man Alive Foundation, the MCT has acquired the services of Charles B. Cox as its Planning Consultant;

— seeking funds from public and private sources to improve the quality and quantity of local drug abuse treatment services;

— assistance to programs and groups regarding drug use and control;

— seeking decent jobs for rehabilitated addicts;

— cooperation with State and local governments in offering the accumulated expertise of the member programs;

— a vigorous campaign for adequate medical treatment for addict inmates in penal and detention institutions.

The Medical Coordinating Team states its policy as —

(TREATMENT) 1. Emergency Treatment Centers for Narcotic Addicts and Drug Abusers.

Crisis intervention, and intake and evaluation centers should be developed within the emergency service facilities of the existing hospitals interested in the drug abuse problem; and that, in addition to emergency room treatment, provisions should be made for evaluative interviews and for taking the first step toward long-range treatment immediately after emergency treatment.

2. Coordinated Decentralized Intake and Referral

The MCT favors the development of coordinated, decentralized intake centers for all types of drug abusers with cross-referral to appropriate modalities of treatment; and a central information center operated by the MCT programs.

3 DRUG ABUSE TREATMENT CENTERS

Treatment centers should be readily available and accessible to population centers; any given treatment center should have a maximum patient load of 200 patients, and its treatment modalities, identifiable within the larger organization, may or may not be separately located from the program center. Service should include both medical and counseling facilities and offer a variety of treatment modalities including methadone maintenance clinics.

a. Therapy for Individuals, Families, and Groups

MCT member programs will strive to offer therapy in any possible and appropriate form for individuals and groups in the programs, and for the families of addicts on programs.

b. Legal Assistance for Addicts

MCT member programs will continue to provide access to legal assistance for all addicts on their programs as part of their basic program services...but specifically for addicts who are unable to afford adequate legal counsel for themselves.

c. Rehabilitation of Addicts

The MCT encourages any appropriate form of rehabilitation and follow-up procedures which assist addicts to make a successful adjustment to use roles in society; and MCT member programs place strong emphasis on job placement as essential to the addict's adjustment. Where job-placement is gainful employment is difficult or impossible, vocational training and/or further formal education with financial assistance when needed is considered to be important elements of a successful program as well as of successful rehabilitation of individual addicts.

d. Addict's Access to Medical Assistance, Welfare, Etc.

MCT member programs will continue to seek resources for third-party payments from State, Federal, and private sources in order to offer financial assistance to addicts on programs who are in demonstrable financial need.

c. Use of Ex-Addicts in Drug Programs

The MCT encourages the use of ex-addicts wherever possible as employees and volunteers within drug treatment programs in order to draw upon their valuable experience with drug problems; and seeks to have such persons further their training as needed.

f. Outpatient Services

Detoxification Facilities

All MCT programs ought to have detoxification facilities readily available for their use. The process of detoxification is viewed by the MCT as part of a treatment track and not as a treatment in itself. Patients discharged from methadone programs should be detoxified over a reasonable time period, i.e., 10 to 30 days.

METHADONE MAINTENANCE PROGRAMS

Counseling Centers

Counseling Centers should be an integrated part of all ongoing treatment programs. The MCT will endeavor to gather and distribute to the public standardized packets of information on drug abuse. The MCT agrees that all personal information derived from the counseling and referral of addicts must be treated as privileged communication of the highest confidentiality.

g. Inpatient Services

Residential Treatment Facilities

Residential treatment facilities should be affiliated closely with operating drug treatment programs in order to draw on such services and treatments as provided by treatment programs.

Therapeutic Communities

The MCT approves of the establishment of therapeutic communities of a permanent or long-term nature which have some affiliation with treatment programs for supportive and medical services.

4 Follow-up Services

Patients in drug treatment programs should be encouraged to seek follow up services, and programs should try to provide such services for patients who are discharged from treatment, in the areas of supportive counseling, continued vocational training, legal services, etc., wherever indicated.

3. Addicts before the Courts and in Prisons

MCT member programs will not accept as patients into their programs addicts who are sent against their will by the courts of any treatment modality, as in civil committent cases. The MCT encourages, wherever feasible considering the nature of the offense, court-supervised referral of drug addicts to appropriate drug treatment modalities rather than to immediate imprisonment.

Addicts on methadone maintenance programs, and persons with street habits of opiate addiction, should be detoxified with methadone over a period of 10 to 30 days when demonstrating withdrawal symptoms in incarceration.

6. Law Enforcement Relations

The MCT encourages good relationships with all law enforcement agencies in their pursuit if the control of illegal drug traffic and use.

THE ROLE OF THE MEDICAL COORDINATING TEAM

1. Planning and Consultation

The MCT views its proper functions as being the coordination of activities of its own member programs, and offering of consultation to governmental agencies, especially in the area of comprehensive planning concerning drug abuse treatment in the Baltimore metropolitan area.

2. Research and Evaluation

MCT member programs agree that data gathering and research on such topics as the extent of drug use locally, the quantity and quality of services provided by its member programs, and the development of mechanisms for program performance evaluations and studies of the effectiveness of various treatment modalities, are appropriate subjects to which the MCT should address itself so that member programs can deliver the best possible service to their addict patients.

3. Public Attitudinal Change

The MCT will continue through its several member programs to provide speakers to public and private groups as requests for such speakers are received. The MCT encourages dialogue and consultation with the professional community (physicians, nurses, teachers, social workers, attorneys, etc.) Educational services should be part of MCT member programs in order to share expertise on drug problems with those who can apply this knowledge in their own fields in a broader effort to meet the problems of drug abuse.

THE USE OF "SOFT" DRUGS

The MCT discourages the use of marijuana because ... are insufficient data at this time to make a firm judgment and, most of all, because it is use is currently illegal. The MCT feels that serious research should be conducted to determine the short and long-range effects of marijuana, and urges periodic review of all laws pertaining to its distribution, possession and use. The MCT is opposed to the abuse of all drug substances, especially barbiturates and amphetamines, and their use without the consultation and supervision of a physician.

—Conaway charges

(Continued from page B-8)

other CAA programs.

"Now that the fiscal juggling comes to light, it is certainly unfair that this important facet of Community Action Agency services, probably the people working closest with Baltimore's economically deprived residents, are being made to suffer, and along with that those people they are serving are being deprived of necessary services.

"I think the whole situation needs investigating, from the poor fiscal planning to the fact that these dedicated public servants are forced to meet in secret to voice their complaints because they're afraid of losing their jobs immediately if the CAA leadership finds out," he added.

* * *

Conaway questioned whether the transfer of Neighborhood Development people to non-civil service jobs is tantamount to their dismissal and whether the actions were taken in accordance with city charter regulations.

"From what I've been told, those people being transferred were informed that if no more funds are available they will be terminated in two to three months," he said. "What I want to know is how can civil service employees be treated in this manner and what will happen to the Neighborhood Development program if these staff members are forced to leave?"

* * *

Conaway, who promised a fight to make sure both Neighborhood Development staffers and those they serve will be protected, called for the CAA to open its books for a public audit and at the same time suggested that the city comptroller's office explain how the situation has degenerated to its present form.

"From the complaints I've received, it is obvious that the financial workings of the Community Action Agency are the biggest secret in town," he said.

"CAA workers have told me that they have worked for the agency for years and never seen a record of their sub-agency's expenditures . . . and now they're told that there's no more money. I think these dedicated people deserve something more than summary dismissal because of poor fiscal planning."

Conaway said he is presently in contact with members of the Neighborhood Development staff ad hoc committee and was contacting other CAA employees to see if their agencies were similarly affected.

"It's a shame that these loyal employees and the poor people they've been serving are expected to suffer because of sloppy bookkeeping," he said. "And its the worst kind of situation possible when public employees are afraid of bringing such abuses into the open because they are afraid of reprisals. These are situations that must be rectified and I'll be here and now that I will do all in my power to make sure that such abuses will be corrected."

JUNE 12

The personal experiences of parents and children in Baltimore City's foster care program will be the topic of WBAL-TV's "Ch Child in Waiting" program scheduled for today, at 1:30-2 p.m. in color on TV 11.

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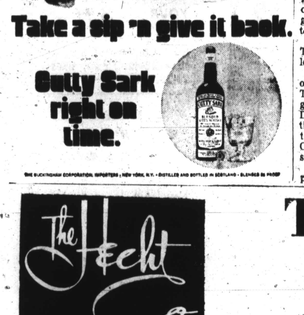

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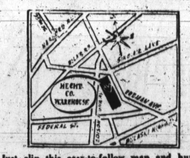

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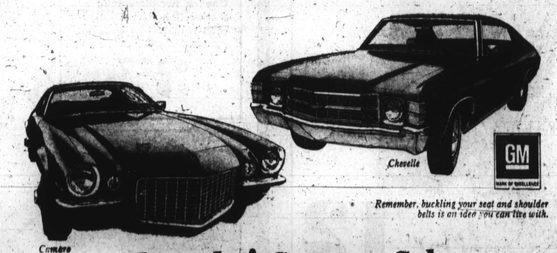

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Now, have a great summer. Chevrolet

Distinguished staff makes Provident tops nationwide

Provident Hospital's Sunday dedication of the new complex at 2600 Liberty Heights Ave. brings to attention the superior quality of the staff and the chain of command of executives and physicians which has threaded through the institution for nearly a century.

An example of the excellence of personnel is the executive director, Henry J. Whyte, FACHA, who is distinguished as one of few persons of his race nationwide to become a Fellow of the American College of Hospital Administrators.

In fact, his training, experience and honors set him aside as a leader among all hospital administrators.

Mr. Whyte came to Provident as executive director Oct. 1, 1965 after 15 years as administrator in other large hospitals including historic Freedmens Hospital in Washington.

Among his published articles is one on assembly line technique which speeds hospital moving printed in the American Hospital Association, January, 1971.

Mr. Whyte has supervision over the entire hospital complex, the more than 900 employees of which 51 are staff, paid physicians; 68 fulltime nurses, 19 parttime registered nurses; 34 fulltime licensed practical nurses and two parttime licened practical nurse.

The payroll exceeds $850,000 a month, according to Charles G. Tilden, associate director for Development and Public Relations.

* * *

In addition to Mr. Tildon, Mr. Whyte's executive staff includes W. W. Walston, associate director for Administration; Mrs. Bernina W. Grady, executive secretary and Mrs. Margaret C. Carroll, administrative secretary.

Mrs. Doris Reese, an assistant administrator, heads the Helene Fuld School of Nursing and is another example of excellence in her field, as to training, experience and ability. She holds many degrees in nursing and public health including a master of science degree from Boston University. Mrs. Reese's career in nursing has extended over a period of 30 years. She came to Provident in 1961.

Dr. Robert L. Jackson, an honorary member of the Medical Staff of over 250 physicians, is an example of longtime and continued service to Provident Hospital.

He started in the early 1920's and since then has "always had Provident Hospital on his mind." The history of the institution shows his influence practically "every step of the way."

In fact, Dr. Jackson and Dr. Emerson C. Walden, composed the first written history on Provident with Dr. Jackson supplying priceless information from memory, from experience and his vast store of accounts and pictures.

The late Dr. William T. Carr was among the founders and first superintendent. His son, Dr James Carr, a longtime staff member, has been associated with Provident since youth.

The New Provident Hospital, Inc., began construction in June 1968.

The main building is seven levels high and is located on a 22½ acre site.

The Out-Patient and Emergency Departments are designed to incorporate the latest thinking in providing ambulatory and preventive patient care and expanded to accommodate twice the present patient load.

The hospital complex is composed of the main hospital building, the nursing school and residence and health science auditorium.

It is planned for four stages of expansion to include facilities for extended care, mental and alcoholic patients.

The first level houses Emergency and Out-Patient Departments with all of the specialized clinics, Physical Medicine Department, Radiological Department, Dental Suite, Doctors Offices for Chiefs of Clinical Services and Meditation Room.

Also, the Admitting Office, General Business Office, Personnel Office, Social Service Dept., Emergency Observation Unit, Snack Shop and Gift Shop.

* * *

The second level has Laboratory Department, Operating Suite, Recovery Room, Cardio-Pulmonary Laboratory, Administrative Suite, Medical Administrative Suite, Nursing Administrative Suite and Medical Records Department.

The third level: Food Service Department, In-Patient Pharmacy, Purchasing and Building and Grounds Departments.

Also, Central Distributing, Inhalation Therapy and Housekeeping Departments and Autopsy.

* * *

The fourth level begins the nursing floors and houses the Obstetrical Department, Labor and Delivery Suite, Obstetrical Recovery Unit, Normal and Premature Nurseries, Medical and Surgical Unit.

The fifth level has Pediatric Department, Intensive Care Unit and Medical and Surgical Unit.

The sixth and seventh floors have two Medical and Surgical Units on each floor.

* * *

There are seven Operating Rooms; two Delivery Rooms; one Labor and Emergency Delivery Room and four Labor Rooms.

The X-Ray Department houses four Radiographic Rooms with all necessary ancillary services.

The Laboratory Department is departmentalized to include all essential functions. A Cardio-Pulmonary Function Laboratory is housed adjacent to the Laboratory Department.

* * *

Out-Patient Services (Emergency and Out-Patient Departments) are merged into an ambulatory patient care facility capable of functioning, jointly or separately, on 24-hour and seven days a week basis.

There is a common entrance, divided by partition for control and leading to a "triage" or "sorting-out area," so that each patient can be examined and screened to properly diagnose and treat the true emergencies as well as care for the non-emergencies.

The Out-Patient Clinic houses all normal clinics, as well as their sub-specialties, with patients being referred to these clinics through a screening clinic.

The Out-Patient Department also houses a Department of Physical Medicine.

Provident projects an Out-Patient and Emergency load of 60,000 to 70,000 patient visits per year.

* * *

The Arts Science Auditorium seating 221 persons is housed between the in-patient facility and the School of Nursing appropriately designed to embellish the training programs of Interns, Residents and Student Nurses.

The goal is to make possible the hospital's goal of becoming a total part of the community and the community an integral part of the hospital.

The School of Nursing can house seventy-four on-campus students with educational facilities to accommodate one hundred (100) plus students.

* * *

Present hospital plans are designed in four stages of construction with Stage One outlined as above.

Adequate and ambitious plans are also contemplated for future expansion in Stages 2, 3 and 4.

Stage two and three are expansions of the Out-Patient Department facilities, since this area is the hospital of the future and need for this service will increase tremendously.

Stage four is planned for expansion to include three areas of hospital operation; namely, (1) the provision of acute facilities for the short term hospitalization of the mentally ill, which at the community level is generally accepted as an essential phase of a well-balanced program of hospital services.

Private hospitals presently provide very limited accommodations in this area.

(2) Expansion for the provision of medical and hospital care for the chronically ill and those persons requiring long-term care which is consistent without basic premise that a portion of the chronic hospital services in the community should be an integral phase of the acute general hospital care.

Provident feels strongly that it is desirable to consider its acceptance of some responsibility in the future for providing chronic hospital care.

(3) The provision for an Alcoholic Detoxification Unit to aid in filling the great void that is now present in caring and treating for this type of patient who is now legally deterfined as an ill person.

The following physicians are of the Provident Hospital Medical staff:

Drs. Ferdinand S. Leacock, Thoracic and Vascular Surgery, Honorary

Dr. Robert L. Jackson, General Surgery.

Consulting

Drs. Louis Goodman, Tumor Surgery; Bernard Kapiloff, Plastic Surgery; Bernard Kapiloff, Urology; I. Bradshaw Higgins, General Surgery; Joseph Miller, General Surgery; Richard A. Montgomery, General Surgery; Harold Rosenberg, Tumor Surgery; Nathaniel Sharp, Orthopedic Surgery.

Active Attending

Drs. William Birt, Urology; Feodor C. Caguin, General and Thoracic Surgery.

General Surgery

Drs. Earl C. Clay, Odom N. Coker, Bernard Harris Jr., Edward E. Holt, Edward O. Hunt, Weinfred e Iglesia, Turgot Jeudy, Harold M. Johnson.

Drs. Thomas C. Jones, Ophthalmology; Wayland Jones, General Surgery; Marcus W. Moore, General and Thoracic Surgery; G. Franklin Phillips, General Surgery; Archie Robinson Jr., General Surgery; William Russell, Orthopedic Surgery; Emerson Walden, General Surgery; Henry C. Welcome, General Surgery; Elroy Young, Orthopedic Surgery.

Associate Attending

Dr. Ralph Howard, Urology.

Courtesy

Drs. George A. Little, General Surgery; Hiroshi Nakazawa, General Surgery; Daniel Wilkerson, Hubert Skinner, Otolaryngology; Lawrence Pinkner, Plastic Surgery.

Affiliate Podiatry Surgery

Drs. Steven Berlin, Lawrence Blazer, Brown, Irvin Donick, Lanny Rubin, Michael Sherman, Allan Sherr, Edward Sibel, John Skolon, Herbert Trader.

Dr. Larry LaBroit, Optometrics.

Chief, Dr. Claude D. Hill, Obstetrics and Gynecology.

Consulting

Drs. Evan A. Gilkes, Obstetrics and Limited Gynecology; Herbert L. Moseley Jr., Obstetrics and Gynecology.

Active Attending Obstetrics

Drs. Lionel A. Deshordes, William Hall, N. Alan Harris, Eugenie E. Phillips, Louis L. Randall, N. Louise Young.

Associate Obstetrics and Gynecology

Drs. Donald Chambers, Willie Daniels, Benigno Lazaro.

Courtesy

Drs. Odom N. Coker, Gynecology; Bernard Harris Jr.

Courtesy

Gynecology: I. Bradshaw Higgins, Gynecology; John Holmes III, Non-Operative Obstetrics; Turgot Jeudy, Gynecology; Ming I. Lui, Obstetrics and Gynecology; Joshua Mitchell, Non-Operative Obstetrics; Marcus Moore, Gynecology; Eugene Owens, Non-Operative Obstetrics; G. Franklin Phillips, Gynecology; Emerson C. Walden, Gynecology; Henry C. Welcome, Gynecology.

Internal Medicine

Chief, Dr. Roland T. Smoot.

Active Attending

Dr. James D. Carr.

Drs. Louis Farmon, Dermatology; Garfield Kington, Internal Medicine.

Internal Medicine

Drs. Elijah B. Saunders, Donald Stewart, Ralph Twitting.

Associate

Drs. Barnett Berman, Gordon Cader, Abraham Genecin, Herbert A. Kushner.

Drs. Howard Moses, Neurology; Jerry Salan, Internal Medicine, Div. of Cardiology; Leonard Scherlis, Internal Medicine, Div. of Cardiology.

Courtesy

Drs. Alvin Brown, Rehabilitative Medicine; Nurredin Erk, Internal Medicine; James McPhillips, Internal Medicine; Jeff Parker, Internal Medicine; Nevzat Turkman, Internal Medicine; Charles R. Venier, Internal Medicine.

Medicine

Chief: Dr. Richard Tyson.

Emeritus: Dr. William Watts.

Active Attending

Drs. Gilbert Banfield, Simon H. Carter, John T. Chissell, Jesse T. Holmes, Joshua R. Mitchell, Theodore Patterson, Uthman Ray Jr., Ralph M. Reckling, Hollis Seamarine, Percival Smith, William Pope.

Associate

Drs. Frederick K. Adams, Robert Blackmon, John Braxton, Garland Chissell II, Charles R. Davidson, John B. De Hoff, Donald W. O. Hughes, Asuncion P. Lazaro, Stanley Madison, Eugene Owens.

Drs. Maurice Adams, Emmett Davis, Stephen Hamerott, John H Holmes, III, Emerson Julian, Richard Massengill, Roland Phillips, Perry Stearns, Fenton Williams, Theodore Wilson.

Pediatrics

Chief: Dr. Eric L. White.

Emeritus: Dr. Charles R. Campbell.

Active Attending

Drs. Vincent Blake, Shirley Clinton, James F. Cooper, William Massoud Kaye, Yulmadge Pinkney, Lionel C. Rose, Sidney H. Saunders, Lawrence Zollicoffer.

Courtesy

Dr. Ewa Soo Lee.

Chief: Dr. Irving Hawkins, Jr.

Emeritus: Dr. Bruce H. Alleyne.

Consulting

Drs. Irving T. Abramson, Charles Alling, Donald J. Forester, John Grewe, McDonald Hamilton, Bettye C. Jones, Charles E. Loveman, Martin Lunin, Donald Lurie, Burton Podlack.

Charles Pridgeon, Oral Medicine; Wilbur O. Ramsey, Prosthodontics; Harvey J. Webb, Group I thru III.

Honorary

Drs. Bernard N. Christmas, Group I through Group V. Charles Watts, Group I and II; Jesse Weaver, Group I and II.

Active Attending

Drs. Curtis N. Adams, Group I thru Group V; Russell Carrington, Group I thru Group V; Bernard H. Christmas, Group I thru Group V; Robert M. Fillios, Group I thru Group V; Martin H. Rodecay, Groups III, IV and Group V; George Taylor, Group I; Henry Williams, Group I thru Group V.

Associate

Drs. William Alexander, Group I thru Group V.

Courtesy

Drs. Kenneth Bethea, Group I and II; Ernest Colvin, Group I and II; Gladstone Davis, Groups I, II and Group III; James Davidson, Group I and II; Fabian Desbordes, Group I, II and Group III; Benjamin Gordon, Group I and II; Irvin Henderson, Groups I, II and Group III; Aaron Jenkins, Group I and II; Robert Rainey, Groups I, II and Group III; George Woodland, Group I and II

Chief: Dr. Addison W. Pope, Psychiatry Group I.

Active Attending

Drs. Arthur Lamb, Psychiatry Group I; John McGee, Psychiatry Group I; George McK. Pillers, Psychiatry Group I; James Ralph, Psychiatry Group I

Chief: Dr. John C. Payne, Anesthesia.

Associate

Anesthesiologist

Drs. Gilbert Banfield, Anesthesia and Medicine.

Courtesy

Drs. Jose Arroyo, Anesthesia and Surgery; Sylvan Shane, Anesthesia.

Chief: Dr. James Bell, Radiology.

Active

Dr. Thomas W. Harris, Radiology.

Courtesy

Dr. Swyit Singh Patheja, Radiology.

Dr. Henry B. Smith, Pathology.

Dr. Edward O. Hunt, General Surgery.

HENRY J. WHYTE

DR. ELIJAH SAUNDERS

MRS. DORIS H. REESE, PN

PROVIDENT HOSPITAL REBUILDING COMMITTEE of the early 1920s dcvoted itself to raising funds so that the Union Memorial Hospital's Union Protestant Infirmary at 1514 Division St. could be purchased for a new Provident Hospital. In December, 1927, the Victory Committee with C. C. Fitzgerald, president of the Provident Board had $425,000; the $165,000 from Baltimore's black citizens, $149,000 white citizens and gifts of $100,000 from other sources. On Oct. 15, 1928 the doors opened at the Division St. site. Provident Hospital stayed there until early 1971 when it moved to the $16 million, 400-bed facility at Liberty Heights and Towanda Aves. Among those on the Rebuilding Committee which raised funds also to renovate the old 413 Biddle St. building while they were waiting for the Division St. purchase to become reality were from left, (FRONT ROW) Dr. E. V. Fitzgerald, Lemuel Young, Wesley Parker and John Williams. (SECOND ROW) Walter Pinderhughes, Ford Dabney, Truly Hatchett, Fearless Williams, Bernard Taylor, Dr. Harry S. McCard, Dr. Harry F. Brown and James A. B. Callis. (STANDING) Samuel Matthews, P. D. G. Pennington, John Hampton, Will White, Henry Hale, John Rich Sr, Dr. E. V. Stokes, Alfred Allen, Dani I Murphy, Ernest Purviance and George Carter. (Photo of the 1950s by A. L. Maebeth, reprinted from the 75th Anniversary Edition of THE AFRO-AMERICAN Newspapers, Aug. 15, 1967).

PROVIDENT COMPREHENSIVE NEIGHBORHOOD HEALTH CENTER'S new $2 million building on the above site just around the corner on Mosher St. from the old 1500 block Division St. hospital, will come sometime in 1973. Above is the Immaculate Conception Catholic Church built when the neighborhood was of middle-class white residents and some 2,000 parishioners barred black Catholics. The school closed in 1945. Below the lot purchased by Provident just off Druid Hill Ave., is the former site of the Immaculate Conception convent, school and clergy residence. The new center will house the facility now located at 997 Edmondson Ave. to serve the 30,000 or more persons in the adjacent neighborhood who otherwise may never have health care.

Shirley Parker Found In Druid Lake Fountain Two Years Ago

THE SHIRLEY PARKER case still remains a mystery after the two years that have gone by since the body of the beauteous 25-year-old matron was found inside the fountain in the lake at Druid Hill Park on June 2, 1969. After searching for more than a month since she was reported missing on April 23, 1969, police reported that the badly decayed body was found by workmen who went to the top of the 35-foot fountain to repair the lights. The body was face up between some pipes, was identified by dental work and her brown slacks, yellow blouse, three-quarter-length coat and knee boots. Joseph Patterson and Vince Santos, electricians, said they were perplexed how she could have gotten into the fountain which has a 4-foot depression inside the top. Water just about 25 feet out of the fountain which is over 35 feet from the retaining wall. A male companion told police in April, 1969 he had persuaded Mrs. Parker to come back from the shore of the lake one night after they had disagreed. He said he returned to the lake a day or so later and found her purse inside the iron fence. Medical examiners have not declared if death was by suicide or murder and the case remains unsolved. Mrs. Parker, the former Miss Shirley Widgeon, was the mother of two sons by two marriages; a former Urban League secretary and widely known in Baltimore. She was residing with her mother, Mrs. Theresa Austin, when she mysteriously disappeared.