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Supplemental Report

Legislative Research Committee

REGARDING THE

Augusta State Hospital

TO THE MEMBERS OF THE

Ninety-first and the Members-elect

OF THE

Ninety-second Legislature

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SUPPLEMENTAL REPORT

LEGISLATIVE RESEARCH COMMITTEE

regarding the

AUGUSTA STATE HOSPITAL

to the Members of the

NINETY-FIRST AND THE MEMBERS ELECT

of the

NINETY-SECOND LEGISLATURE

On August 15th, 1944, an eighty-seven-year-old man named Wilbur Stanton of Windham was committed to the Augusta State Hospital. His relatives visited him on August 29th, and, because of his complaints and their observation as to his physical condition, they returned on August 30th, obtained his release and took him back to Windham. He died during the late afternoon of September 1st. Previous to his death, at the request of some of the interested parties, Harrison C. Greenleaf, Commissioner of Institutional Service, went to Windham, saw the abrasions and bruises on Stanton's ankles, wrists, body and head.

Commissioner Greenleaf called upon Dr. Wescott on September 2nd to learn whether Dr. Wescott would verify an assertion alleged to have been made by him that Stanton had been abused in the hospital. We are informed that Dr. Wescott refused to verify that statement.

Commissioner Greenleaf did nothing further concerning an investigation of this case until September 18th or 19th and subsequent to the time when three members of the Legislature had gone to Windham and talked with the relatives and officials in Windham who were disturbed about the conditions surrounding Stanton's death. Report of this visit was made in the public press.

At the same time that Commissioner Greenleaf resumed his investigation the Legislature was in Special Session and an order was being intro-

duced in the House directing the Attorney General to investigate the circumstances surrounding Stanton's death. Subsequent to the House order Attorney General Cowan ordered the body of Stanton exhumed and Dr. Porter, medical examiner for Cumberland County, made an autopsy.

At about the same time the Attorney General visited the office of Dr. Tyson, Superintendent of the state hospital, and shortly thereafter issued a statement to the press which contained the sweeping accusation that "we have permitted our fathers and mothers, our brothers and sisters, our sons and daughters, when mentally ill, to be shut up under conditions such as no good farmer would impose on his cattle."

Commissioner Greenleaf then announced to the press that, upon the Governor's order, he intended to engage an impartial, independent expert to make an inspection of conditions at the hospital. The Legislative Research Committee, in conference with Commissioner Greenleaf before the expert had been engaged, suggested to him the impropriety of a department head securing an investigator to investigate conditions in an institution in his own department. Mr. Greenleaf persisted and engaged Dr. Raycroft of New Jersey, a medical doctor and a man of experience in institutional work.

Dr. Raycroft's report, when released, expressed the conclusion that the management of the hospital and the care and treatment of the patients was being maintained at as high a standard of excellence as could be expected in view of the enforced shortage of medical and nursing staff and attendants. He did, however, point out the limitations which were placed upon his investigation by Commissioner Greenleaf, saying that his inspection was to "be directed toward the statements contained in the Attorney General's report and not on an over-all investigation of the organization and management and operation of the Augusta State Hospital."

Upon publication of Dr. Raycroft's report the Attorney General reiterated his former charges concerning deplorable conditions at the hospital.

Because of the Attorney General's insistence, and because of the auspices under which Dr. Raycroft made his inspection and the limitations placed upon what he should do, it became clearly incumbent upon this Committee to institute its own investigation of the situation in the hope that its independent position as a legislative agency, in no way connected with the administrative functions of the government, might make its report more authoritative and definitive to the people of the State of Maine who may very well feel greatly disturbed as to what treatment

their friends and relatives, and other citizens of Maine, are receiving in this state institution.

The Committee was fortunately able to obtain the services of Dr. George S. Amsden of Acworth, New Hampshire. Dr. Amsden is a psychiatrist of outstanding ability and reputation, with many years of service as an administrative official of mental institutions in New York.

At our request, but without ever meeting any members of this Committee, Dr. Amsden went to Augusta on Friday, December 15th, and started an investigation of the hospital on Saturday, December 16th.

The Committee met Dr. Amsden for the first time on Wednesday, December 20th, after he had spent two or more days in going over the hospital. Before we received his formal written report we had Dr. Amsden, in a closed session of the Committee, tell the Committee what he had found and answer all questions that were put to him by members of the Committee. Thereafter Dr. Amsden submitted his written report in which he states the directions which he received from the Chairman and Secretary of this Committee as to the investigation which he was to make, and which directions show that the Committee placed no limitation or restriction upon the course or scope of his investigation.

Dr. Amsden's report is entirely a favorable report as to the administration of the hospital under its Superintendent, Dr. Tyson. The highlights of his report may be summarized as follows. The Augusta State Hospital has a serious shortage of personnel, in common with other similar institutions all over the country. Where the normal working force of attendants and nurses for the number of patients would be 180,—at the present time it is 65. While the proper capacity of the hospital is 1,270, there are patients there to the number of 1,500, many of them senile of the type of Mr. Stanton. That while the normal staff of assistant physicians under Dr. Tyson should be 9 or 10, there are now 3.

After talking with Dr. Amsden, and knowing his qualifications, the Committee felt full confidence in his report, but, in order to shirk no duty, however unpleasant it might be, the Committee, with no advance notice to the authorities, visited and inspected the hospital on Wednesday afternoon, spending the afternoon traveling through the wards. Every member of the Committee was impressed by the cleanliness, not only of the floors, walls and furniture, but of the linen and other clothing, all of which was freely opened to our inspection. We had the opportunity to observe, and did observe, the general attitude of patients toward Dr. Tyson and toward the attendants whom we saw there in the wards. We inspected the dining rooms and the kitchen, and saw the supper that had been prepared for the patients for that day's meal. We saw the cooking utensils used, which were clean. We saw the hot food placed

in heat retaining containers for transportation from the central kitchen to the dining rooms. Everything that a group of laymen, inexperienced in institutional work, could observe was of the highest order.

The next day the Committee called Dr. Tyson before it and questioned him concerning the hospital and its operation.

In view of the statements which he had made, the Committee called in the Attorney General and discussed with him the basis for the charges which he had made.

The Committee also had Commissioner Greenleaf before it and asked for his views on the situation, and inquired of him concerning his conduct of the investigation concerning Stanton's death.

In view of the fact that the State Statute sets up qualifications to be required in the Commissioner of Institutional Service we inquired into his experience prior to his appointment.

The Committee also had Drs. Porter and Gottlieb, recognized experts in pathological work in connection with autopsies, before it, and obtained their expert opinions derived from the autopsy performed on Stanton's body.

We attempted to obtain from all of these people, who might be able to assist, whatever opinions they had as to what might be done to improve conditions at the hospital in the post-war years.

CONCLUSIONS

From the evidence given the Committee it is obvious, and the Committee so concludes, that Stanton died of pneumonia induced by several cracked ribs and that the ribs were cracked while he was an inmate at the hospital. This injury probably resulted from a blow at the front of his chest, which could be a blow struck either by another patient or an attendant, or caused by a fall. For a man of his age no very great force would have been necessary to cause this injury. The cut on the back of his head, which was less than an inch long, was caused in the hospital and could have been caused by any edged instrument, either by a blow, or by a fall against a radiator, a table edge or similar article. The abrasions on his wrists and ankles were probably caused at the hospital and are entirely consistent with some continued restraining pressure put upon Stanton's limbs while he was confined in the hospital.

No evidence has been produced before the Committee which leads the Committee to the belief that Stanton's injuries, resulting in his death, were caused by any brutality on the part of any attendant in the hospital.

It is quite evident that so long as the institution must necessarily operate without its full quota of doctors, nurses and attendants, there must be a certain amount of risk involved in the care and protection, particularly of these senile cases. It is a characteristic of seniles that they are fumbling, groping persons of clouded mentality. They may be passive and cooperative or they may be aggressive and obstinate, as was the attitude of Stanton. Because of their advanced age and physical condition they are peculiarly liable to accidental injury from falling or being pushed by other patients. It is noteworthy in this connection, however, to quote from Dr. Amsden's testimony as related to patients of this type:

> "Here is a large group of these helpless and senile arteriosclerotic patients; they are sent to this hospital; they are reasonably well cared for. Supposing you say, 'We cannot continue this; we have got too many; we can't afford it,' these patients would have to be left to nondescript care, and they would die off like flies. The cost that you are put to in the way of accidents that happen, looked at from the welfare of the patients as a group, is small. That is, one or two patients, a few patients, may have something happen to them. If they did not have this facility they would have a very great deal more happen to them; they would suffer infinitely more."

That risk seems entirely justifiable today when the manpower of the country is so sorely needed in the war industries and in the armed forces.

It is the view of the Committee that the hospital authorities were lax in their own behalf and for their own protection when they did not make a thorough physical examination of Stanton before releasing him from the hospital. In the present instance it might have avoided a great deal of the disturbance which has grown up about this case.

The Committee further believes that Commissioner Greenleaf did not show the proper zeal in following up this matter after it was called to his attention on September 1st at Stanton's home. After making an inquiry of Dr. Wescott on September 2nd the Commissioner did nothing concerning this matter until it became apparent that the Legislature was interesting itself in the matter and that an investigation was to follow. If the Commissioner had shown more interest in attempting to fix the blame for Stanton's death by a vigorous inquiry on his own part he might have made the public feel that the institutions were being zealously supervised and their conduct watched.

It is not the duty of this Committee either to approve or condemn appointments made by the executive; those are within the discretionary

power of the Governor and Council. When, however, a Legislature has laid down a standard of qualifications for an appointment it is within the province of this Committee to point out what those statutory qualifications are and to indicate what the experience of an appointee is. The public may draw its own conclusion as to whether or not those qualifications are met. The Committee has further reason for pointing out the statutory provision in this case because it is entirely possible that a Commissioner more experienced in institutional work would have been more alert to his duty in connection with Stanton. The statute says, "The Commissioner of Institutional Service shall be a person experienced in institutional administration, either as a superintendent, chief medical officer or business manager, or who has had other satisfactory experience in the direction of work of a comparable nature." Commissioner Greenleaf testified that his experience prior to his appointment was first as a newspaperman, and, secondly, for a short time, as an OPA Administrator.

It is the opinion of this Committee, from the reports of the two experts and from its own observation, that abuse of patients in this hospital is rare or non-existent. We know, from the rules and the records of the hospital, that any abuses are not tolerated and will result in dismissal if detected. We are satisfied, from our own investigation and observation of the attendants, that their attitude toward their charges is not one of hostility.

In fairness to the Attorney General we state that he has obtained statements, and in some cases what he calls "confessions," from former attendants and some discharged inmates, as to abuses which are alleged to have occurred at the hospital. There are also many statements from former and present attendants testifying to the splendid care and protection given to the patients. The statements of some of the former attendants are obviously prejudiced and embittered by the fact that they had been discharged for infractions of the rules of the hospital. We are not convinced, on all the evidence, that these statements afford credible proof as to present conditions at the hospital.

Furthermore, it is the opinion of this Committee that the Attorney General would have served the State of Maine better by prosecution of persons whom he might feel were guilty of assault and battery in the hospital, than by such broad and sweeping charges as he leveled against the hospital administration, to the disturbance and unquiet of all the people in the state who have an interest in how the institution is run.

It is not fair to say that a niggardly policy on the part of the Legislature has produced all the shortages of manpower which exist at the hospital. The Auditor's report points out that the Augusta State Hospital at the end of the last fiscal year turned back $35,000.00 of its appro-

priation which might have been used for increased salaries. We do agree with the administration policy that the State of Maine in its institutional services should not attempt to compete for men and women by offering wages comparable to those paid in war industries in an attempt to attract manpower from the necessary war industries. While our institutions must be run at a safe and decent level they too must assist in the war effort.

The Committee concludes with recommendations, to which succeeding Legislatures should give serious consideration, to a solution of the three major shortcomings of the institution as it exists at the present time. First, at the proper time, there must be a wage scale and hours of duty which shall be sufficiently attractive to draw in the full quota of nurses and attendants necessary for the proper operation of the hospital. Secondly, there must be sufficient additional building space to prevent the overcrowding which now exists and to anticipate the needs of an increasing number of seniles who will inevitably be sent to the state institution in the future. Thirdly, the medical staff must be trebled in order to do something more for those persons afflicted with a type of insanity which is capable of amelioration or cure than simply to maintain a protective custody over them which keeps them from injury.

Dated at Augusta, Maine, December 28, 1944.

Respectfully submitted,

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