

**Kenneth Gaver, MD**

**Oregon State Hospital**

**Administrator, Mental Health Division, 1966 –1971**

**Interview – April 16, 1999**

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I: You began as a resident in psychiatry at OSH in 1953.

KG: Yes, in August of 1953. They had a one-year residency at the time and some of the other people who were doing their residency there were Joe Trelevan, Reed Kimble, myself; Joe Trelevan who was the first administrator of the division. I stayed for a year and I was assigned to the men's receiving in old Ward J where we six to ten, twelve admissions a day. When I first started working there, Dean Brooks and I were the doctors assigned. He was part time. We had a total of thirteen physicians on the staff.

I: For the hospital?

KG: For the entire hospital including the superintendent who was an opthamologist and two people who were surgeons and two people were dermatologists. We had zero PH.D. psychologists. We had one MSW in those days.

I: The psychiatrists were the professional people basically?

KG: Yes, such as they were. There were only two or three that ever completed training. I only got a year and a half of training plus I had a lot of prior experience. I had worked at a psychiatric hospital in the Navy before I went to medical school. I had actually done that hands on as a psyche technician. Most of the time through medical school I worked at the University Psychiatric Hospital, as what they called an extern, sort of a mini-doctor. I had done some research for the Department of Psychiatry so I had quite a bit of experience before I got to OSH. Dean Brooks and I were there and it was divided at that time into men's admitting, women's admitting, men's treatment and women's treatment. Then there were the long-term units. The maximum security long term units where lengths of stay were ten, twenty, thirty years. I discharged a patient that had been in the hospital fifty years at one point in time. In those days, we did our work up. We didn't have any drugs. As a matter of fact, Thorazine became available in the first year of my residency. We were using a lot of electric shock. A fella in the men's treatment unit was doing a lot of insulin coma therAPAy. We did metrasol shock.

I: What was that?

KG: Metrasol was a means of inducing a seizure by the injection of metrasol intravenously. Do you know what insulin coma therAPAy is?

I: Yes.

KG: We had done a lot of that and I had done that before in the Navy and at the university so that was nothing new.

I: Did you find it effective?

KG: We had no controlled studies. It seemed to be effective in some patients but it may have been that they got an enormous amount of individual attention and that may have been as important as any of the physiologic changes they went through. They staffed those units very

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intensely. They were also very sensitive to staffing. When I was teaching insulin coma therapy later on at Indiana U, if you just changed the nursing staff, the patients reaction to insulin would change. So there were physiologic responses to changing the nursing staff. When we would bring in nursing trainees we had to be very careful to introduce them carefully because otherwise the patients reacted. One of the things we had in those days back in 1953, '54, was called a chicken coop. The chicken coop was a sixty-five-bed unit comprised of totally bedridden women with bedsores. When you had major rounds on Saturday and were on call you changed all the bed sore dressings.

I: Did they get out of bed?

KG: No. They were all bedridden.

I: Just completely bedridden.

KG: Yes. There were 3500 patients at OSH and 1500 at Eastern Oregon Hospital. There were 5000 people in the state mental hospitals in Oregon then. Dammasch had not yet been built. About the only formal training we had, and this is an important name besides Dean Brooks was John Waterman. Have you heard of John and Minnie Waterman?

I: Yes.

KG: You know about their early work with child development clinics?

I: Yes, he and his wife.

KG: Yes, and the health department of course was the one who planned those child development clinics. Waterman worked for them. John gave us some training but most of it was learn by yourself and see a lot of patients. It was fine but I had some formal training before. After a year, I stayed on for another half year doing the same thing basically and then went out to finish my residency at Indiana U for a year.

I: Are you saying that you really spent most of your time working by yourself with the patients and didn't have a lot of supervision?

KG: No. When they brought new doctors on I supervised them because I had that much more experience and training than they did.

I: Must have been a little scary wasn't it?

KG: That's the way it was back in the 50's. For example, in 1947 or 46, in between my second and third year of medical school, I came out to Santa Barbara which is my home. They didn't have a doctor at the county hospital. I did all the physical examinations. I carried out the treatment, other instructions, the visiting doctors from town who came in and said, do this, do that, and I did it with two years of medical school. Finally they got one there. There was a very grave shortage of people. We didn't have a plethora of people the way they have today. If you

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wanted a degree in social work you had to go either to Denver or Seattle to get a masters degree. It was that far away. We had some master's degree psychologists, one master's degree social worker for the entire hospital, very few nurses with specialty training. It was just a matter that you did what you could with the limited drugs you had and the limited staff you had. We used a lot of seclusion, restraint, electric shock therapy, and insulin coma therapy. You probably never heard about this but we also had what was called a board that made the determinations whether or not you castrate sexually active people.

I: Yes. The board of eugenics.

KG: No. It wasn't the board of eugenics. It was a local board at the hospital. I'm not sure what the relationship was with the board of eugenics but basically at the hospital the decision was made by the superintendent and doctors. Charlie Bates, the superintendent put me on that board and we never did another one. We stopped it. We were still, in those days, doing some prefrontal lobotomies.

I: Did you do those?

KG: No.

I: The surgeons did?

KG: The surgeons did. It was a very simplistic sort of thing. When I came back after I had finished the year at Indiana U, I wanted to go back to Oregon. I came back as the Director of Education and Research. At that time we had a residency program, I don't know at what point we got it changed from one year to three years. Every student nurse in Oregon and Washington came to OSH for their three-month psychiatric rotation.

I: That was a big boon wasn't it?

KG: Yes. Student nurses were a big boon. Of course there was a time when one of the student nurses misinterpreted drams and ounces and gave ounces of the medication instead of drams and one patient died. The rest of them were up all night. But it was an honest mistake and they didn't kick her out of school. Dean Brooks would tell you that back in World War II, patient help filled rat poison and a number of people died but nobody even sued. I came back in January '55. At that time we were able to begin to purchase a library and build a library. Build a residency program and get in some people to help teach the residents. I did a lot of teaching of the student nurses along with the nurse instructors. I developed a relationship with the UofO Department of Psychology and brought psychology students up to do some interesting things on units. We would put them on the units without any indication to the patients they were tied to the hospital. They were just observers from the university. They would give some interesting reports. If the attendant didn't like the doctor they wouldn't give the medication.

I: No kidding.



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KG: Yes, these things went on. We started to train these attendants because they hadn't had any training. You would bring them into the room where you were going to do the training. All the men would sit on one side of the room and all the women would sit on the other side of the room because they were segregated.

I: In their units?

KG: Yes. The units were totally segregated and they felt that way. So we fooled them. We mixed them and put the chairs in a circle. Then the men sat in half the circle and the women sat in the other half of the circle. There were some interesting things that went on. There was an after care program of sorts that was provided by public health nurses and the county health departments. They tried to actually do home visits for patients who had been in the state hospitals. They came in and when I was director of education and research we put on a training program for them. Also at that time the nursing homes in this state, there were fewer patients in nursing homes than in the state hospitals, they were just beginning to rise. They came and asked us for a program on the care of geriatric patients, which we put on.

I: It was really helpful I'm sure.

KG: I don't know. But those are some things that did go on.

I: Was that before there was any social security for this older population?

KG: Yes.

I: It was. So who paid for their nursing home care?

KG: They were in their own homes.

I: So you would train their parents or their family?

KG: The nurses went out and dealt with the families.

I: I see.

KG: They were mostly adults rather than children and adolescents. There were no facilities for children and adolescents. In 1957 we got a big grant from the national rehabilitation association for an extensive research project in rehabilitation. Have you seen that report?

I: I have. As I understand it the results were inconclusive although it was a very extensive study.

KG: Yes. One of the things that did do was it brought health, vocational rehab, welfare and the state hospital together. It was the period before the mental health division even existed. It brought them together to develop some sort of collaborative relationships and that also facilitated the business of the nurses. They say they divided OSH up into different catchment areas by

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multi-county. That was an idea that I brought back from New York. They sent me and another fella on a month long tour of the country to look at rehabilitation facilities. That was kind of unusual. We went to a lot of different places.

I: Did you find some good programs?

KG: No. Not in those days. What it did do was that it got the division of vocational rehabilitation interested. They were involved and they had a counselor working on the experimental unit of which I was the medical part, a nurse, a masters degree social worker and a voc-rehab counselor as the key team on that unit. That developed a long-standing relationship between myself and some of the other people in vocational rehab so that they began an extensive program of trying to learn about and teach their counselors what to do with the mentally ill in terms of vocational rehabilitation. Over the course of the years, even when I was in private practice after that, I spent a lot of time going to their conferences, mingling with them, teaching some of the things they had. I did a lot of consultations and evaluations in terms of what was going on in the degree of impairment. I had a very close relationship with them for many years. There were other people who did the same sort of thing and brought people together even if it didn't produce any very conclusive research results.

I: Any hard research results?

KG: No. It was about this time also that they were designing Dammasch. The original plans for Dammasch called for 1500 beds, 450 beds in receiving, 500 beds long term and 500 beds geriatric. They of course never built anything but the first 500 beds. The architect who did that did go out and spend a lot of time talking with staff who worked in the hospital at that time. I spent a lot of time with him, some of the nurses did. When you were talking about segregation, Russell Guiss was the first superintendent. Russ was a surgeon. He and I were sitting with the architect and trying to design the men's receiving unit and the women's receiving unit. I wanted there to be a common area between. Russ couldn't stand that. The compromise was that there was a wall built down the middle between the two dining rooms. The compromise was a door so that sooner or later you could open the door and let them co-mingle.

I: As they do in real life.

KG: Yes. It was that way in other places. I was a consultant over at Eastern Washington State Hospital. The men sat on one side of the big dining room; the women sat on the other side. It was all segregated.

I: What was the idea behind that?

KG: I think they were afraid of the sexual activities of patients. At one time, Ward 36 of the state hospital had a lot of sexually hyperactive psychotic individuals. Those were the ones that the superintendent wanted to have the organectomies on. He used to say I want those oysters on the table, Charlie Bates. We wouldn't go for it. That was also a Ward, in those days, they never had a shortage of tobacco. Tobacco was distributed by the hospital and you could roll your own. Tobacco was very much sought after and Ward 36 never had a shortage because most of the

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patients were incontinent. So the staff traded the toilet pAPAer from their ward for the tobacco from the other wards because they never had enough toilet pAPAer. It was tough.

I: Why were they incontinent?

KG: These were very seriously, long term, demented, probably organically impaired people. They had all sorts of brain disorders.

I: I think it was Brooks who told me one of the changes he brought about was bringing in adequate toilet pAPAer.

KG: Do you remember the great toilet tissue issue?

I: No.

KG: That is what Dean was talking about. It hAPApended when I was the administrator of the division about 1969 or so. There was a complaint. It hAPApended when we testifying in the budget hearings before the Joint Ways and Means Committee. The legislative committee got wind there was a shortage of toilet pAPAer. Doctor Brooks was just confounded. He said, I have ordered plenty of toilet pAPAer. I am tired of people not having enough toilet pAPAer but we still have a shortage. The problem was when I went out and looked at the toilet pAPAer I found there were only 500 sheets to the roll instead of 1000 sheets to the roll like I thought and I sat and counted the toilet pAPAer sheets to make sure. Then he said, we discovered the problem.

I: Amazing. So you had to figure things very closely for your budget I am sure.

KG: Yes. There was like a cost per patient per day which was under \$7.00 because I can remember arguing before the national advisory mental health counsel in Washington. They were spending a lot of money at St.Elizabeth's on research. I said, how can you afford to do that when the amount of money you have for room and board and food in a state hospital is like \$7.00 a patient per day. That didn't make me very popular. Bert Brown was the head NIMH and we were personal friends so he didn't take it personally. I wanted you to know about that thing with the rehab program. I left after it started and went up to the medical school. There was a choice about who was going to become superintendent of Dammasch State Hospital, Russell Guiss or myself. I decided instead I wanted to go up and teach at the medical school because we had just got our first full time professor.

I: At the medical school?

KG: Yes in the Department of Psychiatry. We had never had a full time faculty. We had part time and voluntary faculty.

I: Why is that? Was psychiatry just an emerging field?

KG: Psychiatry has always been a stepchild of medicine. In the first place, the opinion of most physicians is that most of the patients are kind of funny and most of the psychiatrists are

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kind of funny. You don't get paid very well and there is no way to pay for them and they are a lot of trouble and they cause trouble so they have always been a stepchild. Furthermore, they have all these psychoanalytic theories which we don't understand. Psychoanalysis practically ruined psychiatry in this country.

I: Really?

KG: Oh, sure.

I: Because?

KG: Because it was so widely accepted and so widely taught that it was based on a set of theories which had never been verified. Other interesting things which you would be interested in and there is a whole book on the subject. They invented a whole new language that nobody in the other scientific fields understood. The sociologists, the psychologists, the physiologists could talk to each other but psychoanalysts had a separate language.

I: A special club?

KG: A special club. Most of my psychotherAPAy supervision was by psychoanalysts and I liked it at the time but just as a philosophy I think it was a disaster. Anyway I went to teach at the medical school and they got their first full time faculty just the year before, Dr. Saswell. With him came two psychologists, Joe Materatzo and his wife who is still here. Dr. Saswell is still here and he is in his nineties now. I was the first additional person they hired to come in on a full time faculty and run the inpatient unit at the medical school.

I: When did the inpatient unit start?

KG: It started about 1957.

I: What was the impetus for having it?

KG: \_\_\_\_\_ he said, I have to have a psychiatric unit. You wouldn't get a German without an inpatient unit in those days anyway you didn't.

I: Is that right?

KG: Of course not. You had to have something for them to teach and some subjects for them to teach with.

I: So they opened it up for psychiatric patients?

KG: On the fifth floor of what was then a new building. It's an old building now. The architect didn't consult anybody who knew anything so they built one of the most god-awful structures you would ever run into to try to do a psychiatric practice in.

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I: How many patients did they have?

KG: Thirty-two.

I: Were they people who had private insurance?

KG: Yes. That would be in the 50's. They had private insurance or the medical school's funding would pay for them. Not many people had insurance in those days. That didn't really come along until the 60's. As a matter of fact when I was in private practice from 1958 to 1965, I used to see lots of new patients. I saw hundreds of people. Only two ever had any insurance that covered their office psychotherapy.

I: So it came out of pocket?

KG: One worked for the post office department. The other one was the wife of the chairman of the department of mathematics at a local university. Everybody else paid out of pocket.

I: How much did you charge for a session?

KG: I started out at \$15.00 per hour, \$25.00 for the first visit, then \$15.00 per hour in 1959. My schedule was full in six weeks but then I had been at the medical school and state hospital. I knew the community and I had also done some teaching for the hospitals down here in Salem. I stayed at the university for a year and I decided that wasn't my life. I came down and started in private practice in Salem and stayed there until I became assistant administrator for the division. It was about 1964 that they had the mental health planning board. You probably read the minutes of that or you found that. I was on that and chairman of the committee for laws and legislation. There were a lot of people on there. That was the impetus that called for the creation of the division of mental health. At the same time that they created the division of mental health they included mental retardation within that even though they called it just the mental health division.

I: You had drug and alcohol and tuberculosis?

KG: No. Tuberculosis was separate. That was under the department of health. There was an Oregon Alcohol Education Committee, which is funded through the liquor commission. They had a little clinic down here on Third Street and Washington, in the Eaton Building. In 1954, when I first came to Oregon, they needed a psychiatrist one night a week. I went up there as a consultant for one night a week. Incidentally that is how I got my license. You had to get a license then. I had a license in California.

I: For psychiatry?

KG: To practice medicine. It was all right if you were a resident if you had a good license in California. I had to get an Oregon license, which meant I had to take an oral examination by the Board of Medical Examiners. We had one question, what does the board do about alcoholic doctors?



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I: That was your exam?

KG: Yes, because that was what they cared about. There was only one place in the whole state privately that treated them. We saw a lot of them in the state hospital.

I: Is there a lot of alcoholic doctors?

KG: Yes. Alcoholic what?

I: Doctors?

KG: No, I meant alcoholic patients.

I: So we aren't talking about doctors?

KG: No, we're talking about patients. The board wanted to know what we would do about alcoholic doctors. There was only one place in the state that treated them as an inpatient, Raleigh Hills. We had this little clinic down here, which saw a few patients and the state hospitals in Eastern Oregon and Salem. Nothing else existed. When the mental health division was created they transferred that in. They had a kind of a dynamic guy there who was the executive director; he was the first one. When they first transferred it in they didn't do much more than they had. They started trying to do some work with the few community programs that existed. They tried to get some units established in the general hospitals but they were very resistant to that sort of thing.

I: Can I ask you a question to clarify that? You treated alcoholics in the hospital?

KG: Yes.

I: You had them come in.

KG: We had them dry out.

I: It was basically drying out. How long would they stay?

KG: The policy back in those days was that you didn't put them out. Most of these people were drifters. As a matter of fact they did a lot of the work around the hospital. We used to talk about the winos, dinos and dingbats.

I: I know the winos and the dingbats. What are the dinos?

KG: They were just the poor kind of borderline people who just never quite got it made. They would come in the state hospital when they would get an episode of some kind. There was no place to put them out. There was no place to put them unless you just dumped them out on the

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street. They stayed around the hospital and did all the labor and worked and finally they would get placed out again.

I: So that is where they got a lot of their patient labor force?

KG: Sure. The winos and the dinos.

I: What was the third one?

KG: The dingbats.

I: It was sort of folklore and that is why we are doing this is to get at that kind of thing.

KG: What did we used to call some of the ancient old being retarded telling us about the tenants who had been out of work for years? I'll think of it, we had a special name for them.

I: The patients that stayed there and did all the work?

KG: No, I mean the salaried attendants. Bughousers. They were the people who worked there fifty years.

I: I know. In some of the state hospitals I have been there are three generations.

KG: Yes. That is right and in institutions for the retarded, too, generations of people. In many instances they are the biggest employers in town. I can remember in Chillicothe, Ohio, an institution for retarded there. In that county they provided 25% of all jobs in the county. I came back from the medical school after just one year, entered private practice in Salem and stayed for five years. During that period of time, Reed Kimball and I who was my partner, also began to be involved in the teaching of the residents at the state hospital, doing seminars and workshops. They also, at that time, had what's his name come in from the therAPAY community.

I: I don't remember his name.

KG: You have it down somewhere. He came and tried to do his thing there. I'm not sure how much of an influence he had.

I: Didn't the wards then subsequently open up?

KG: That was a movement across the country in those days to begin to open up the wards. That was not unique with him. That was going on across the country. Voluntary commitments far exceeded court commitments almost all the people, the vast majority, were voluntary. In those days if they wanted to stay, they could.

I: Families paid part of it, didn't they?

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KG: They could. The board of control could charge families for a portion of their care. I have some information here about the collections year by year and how it changed over a period of years. I also continued teaching at the medical school when I was in private practice. It was also during this period of time that the Oregon Psychiatric Association was formed. It was a state psychiatric professional association. Reed and I also taught part time down at the UofO Department of Psychology. We both went down there and did seminars, lectures and workshops for the master degree students. Subsequently the University of Portland and the medical school developed PH.D. programs in psychology. The first professional pAPAer I ever published was in psychology. You'll get a kick out of it.

I: Performance of Verbal IQ in a group of sociopaths.

KG: Yes. Joe Materatzo was a professor of medical psychology at the medical school. Art Weins was our first PH.D. psychologist at the hospital. He moved up and became full time faculty at the medical school and is still there.

I: What is interesting is the vocabulary, a group of sociopaths.

KG: Yes. There hAPApended to be 128 sexual offenders whom I had examined because there was a law that required all sexual offenders at the time, prior to sentencing, to be examined at the state hospital.

I: A psyche exam?

KG: Yes, so I examined them all for a period of years.

I: Interesting folks?

KG: Yes, it was interesting. A lot of them went to prison because we were very solidly recommending and there was no alternative. They were psychotic or something like that or they went to prison. I used to consult at the prison and you would go over there and all these guys that you had examined as sex offenders would come running up. Hi Doc. Good to see you.

I: You were probably the nicest person.

KG: Sex offenders are the lowest class of criminals and all the other criminal inmates abuse them. They are always glad to see somebody who was half way decent to them.

I: That is a sad story.

KG: Yes. Anyway the Psychiatric Association started. We got the medical school in existence. We were now getting master degree social workers at the hospital and the same thing at Eastern Oregon hospital. They had fewer resources than OSH because they were over there in a rural area. We were getting some PH.D. psychologists. We had a residency program that produced doctors who stayed on the staff for awhile. The medical school now had a residency-training program. It was producing psychiatrists. The nursing students had pretty much moved

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out. They were beginning to get some professional people with some advanced training in mental health. Things were looking up during that period of time.

I: There was more orientation toward treatment?

KG: Right. Remember that there were now many new drugs coming online that had never existed before. The anti-psychotics, they were beginning to develop several of them. At first the anti-depressants came along. Lithium didn't appear on the scene until '63, '64, and even then you couldn't get a patient on Lithium unless he was on a clinical research trial. Paul Blatchley at the medical school was doing that. I got my first patient on Lithium through Paul Blatchley. As a matter of fact, her husband called me the other day and said she is still doing well.

I: That must be gratifying.

KG: Yes. He was a professional. She was a nurse; he was a social worker. He had her hospitalized five times until Lithium came along. There was a whole plethora of new drugs that came that had never been available before. People talk about the major influences. Certainly one of the major influences on the improvement of treatment in the mental health field is the tremendous advances in pharmacology. It has had a profound affect. They made it possible to do things that you could never do before because patients were able now to take part in things.

I: Before would you say it was primarily custodial care?

KG: Sure. You would try to do some group therapy. You would try to do some individual counseling. The alcoholics, who came in, we had an Alcoholics Anonymous program for them and that was about it. They could go to AA in the hospital which Dean Brooks was promoting. We tried to hook them up with AA but there was just very little to do until Thorazine came out.

I: How did people spend their days?

KG: Sitting around.

I: Some of them were farming at this time weren't they? Didn't they work on the farms?

KG: Yes, we did have a farming program then. Each of the institutions did. But trying to use unskilled, untrained, undependable, unpaid labor is not very productive. There was a point when I first became commissioner we had to face that. I convened an advisory group of farm experts from around the country. They came to the conclusion that it didn't make any sense to have farming unless you wanted to make a business out of it. When they created the mental health division and put it under the board of control, Joe Trelevan took that job. Joe had been in private practice too. Have you interviewed him?

I: Yes.

KG: Have you interviewed Don Bray?

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I: No, I haven't interviewed Bray yet.

KG: He followed me. Joe had also been in private practice so he had some sense of that as well as hospitals. You will have to ask him what hAPApended during his period of time. I came in the fall of '65 and in '66 he left and I became the administrator. Two important things hAPApended in the spring of 1966 as far as money was concerned, Medicare passed. On July 1, 1966, we implemented Medicare in the state hospitals, not having any idea how to do it. We were supposed to have a written interdisciplinary treatment plan, which nobody had ever heard of before. It was an idea invented by a nurse social worker and psychiatrist in an institute of mental health who had followed the interdisciplinary education plan, IED plan. So they thought that would be a good thing and that emerged unheard of in the literature before it became a federal regulation. It was amazing.

I: It was a big change.

KG: Nobody knew what to do with it and it took me years to learn how to use that thing. Joe put me in charge of implementing Medicare. I suppose in the spring of 1966 that is what I did most. We had to go around and classify patients. We had to come up with a treatment plan to teach people how to use our rudimentary treatment plan at both OSH and EOH. By this time of course Dammasch was on line and nobody had ever heard of this. Nurses didn't know what it was. Social workers didn't know what it was. Psychiatrists didn't know what it was. It was a real pain in the neck. You also had to have your facilities meet standards, life safety code standards. You got some waivers on that for a period of time.

I: Is this the first time that there were standards at the hospital?

KG: There were some building standards that were local. Nobody had ever heard of the life safety code until Medicare came along and mandated it, at least none of us had. I am sure there were some fire safety people who had. There were no standards for staffing of hospitals except the American Psychiatric Association had put out some rudimentary standards many, many years before. I have a copy here somewhere. At that time there were no standards for staffing the institutions for retarded. Eventually they came along. The American Association for Mental Deficiency developed some staffing standards. Medicare came in and something else really more important came on at that same time. I had come back from a conference in Washington DC where I had learned about these things. The legislative fiscal committee had a hearing about Medicare. They invited me to testify along with other people. When I was finishing my testimony I said, Medicare is really important but of much more impact is Title 19, Medicaid. Everybody said, what is that? They had not heard of it.

I: The federal government?

KG: The state.

I: You were testifying for the state.



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KG: Yes, the state. The fiscal analysts for the state hadn't heard of it. That was the first they had heard. There was this flurry of running around. It was kind of fascinating to see this. They had never heard of Medicaid until I hAPApended to mention it because I had just come from a conference. It would be another year before it came in. Medicaid didn't kick in until a year after Medicare.

I: So you brought it before it had actually been implemented?

KG: Yes. I had just come back and I said this is going to hAPApended. It is very important. It is the most important financial thing that is going to hAPApended to health care in the state of Oregon. The National Governor's Association for years has said their biggest financial problem is Medicaid.

I: After it was passed?

KG: They are talking about currently it is still a huge problem for them. It is like welfare because of the federal/state match.

I: So that had to revolutionize things?

KG: Yes. That came out of Washington of course. Harry Truman originally suggested it and it came out of the Johnson administration.

I: So that meant that there was federal money available to provide services and it is a 50/50 match with the state?

KG: APApproximately, it varied with the state depending on a certain formula. It could be 60/40, 55/65

I: Depending on how many people you served and their economic level or something to that effect?

KG: Yes. It had to do with the economic level of the state and the taxation structure of the state, the average income and so forth. This is some of the information in the '69 legislative session but it has the prior year. Then I will show you what hAPApended after we kicked in Medicaid for the mentally retarded which was really the big program.

I: This money came out of the general fund?

KG: Yes. It had to be matched with general fund money.

I: What I see for 66-67 this is reimbursement for Medicaid, a million and goes up to two million.

KG: This was not for Medicaid kicking in. Medicaid begins to kick in after this. I am trying to find the other report that shows you the difference.

I: I would probably see that in hospital budgets?

KG: No. You wouldn't see it.

I: We are looking at 1965-67 and 1967-69.

KG: Yes in the period of 1967-69, I'm not sure of the exact date, we discovered a way to make the patients in the institutions that were retarded eligible for Medicaid. That was not authorized under the Medicaid bill but I had a friend in Wisconsin who had managed to do that under a waiver. I said, how did you do that? He said, I'm not going to tell you. That made us start talking to welfare. We figured out you could do it. What you had to do was get your institutions for the retarded licensed as nursing homes. Nursing homes were licensed by welfare. You had to have a definition of what was skilled nursing care. The only definition we could find was what welfare had. Then you had to put together a plan of how you were going to do this and how you would meet the now quite stringent requirements and then get the federal government to APApprove it. We got what was called a waiver, a special waiver. We were the only two states in the United States that had that in those days, Wisconsin and Oregon. When you looked at the money it started bringing in, that money was millions.

I: Twenty million.

KG: What you did was add staff, spread the patients out, take patients over to EOH, reduce the number of people per room, per bed, square footage, gradually over time you had to meet some very stringent requirements but you were given three to five years to phase into that.

I: This wasn't limited by age was it?

KG: No. Actually the federal law was not changed until 1974. I testified before Senator Long in the United States Senate. Senator Long wanted to get the mentally retarded included under Medicaid. He had lots of people who were in favor of that. What he needed was clinical information. I hAPApended to be commissioner in Texas at the time. We had a database of 650,000 people with their physical infirmities. We could tell him of the 18,000 mentally retarded we had in our institutions, 67% have a hearing impairment, 57% have a speech impairment, 85% have muscular-skeletal disorder or neuromuscular disorder, which was just what he needed to prove they could be qualified as medical. Senator Long was the one who got that through. The other thing it did was not just cover the institutions, it made it possible for you to move the mentally retarded out into the community in small group homes and get Medicaid payment. I see one, two, three, four and five. That was really only authorized after December, 1974.

I: Did that APApply to the psychiatric patients?

KG: No, this was for the mentally retarded. That really was the fiscal stimulus that led to this and made possible financially for all of these programs for the retarded to develop in the community because there was now money.

I: Did the fact that you and this person in Wisconsin had done this before was that kind of a watershed event?

KG: I don't know how to evaluate that. I do know that we testified before Senator Long about how we had achieved that, both of us did I think. There may have been another state or two that had gotten some waivers by then. Obviously, the federal government, the bureaucracy, was interested in trying this out. That is why they gave a couple of waivers. They wanted to get some experience with it.

I: What was the impetus for passing Medicaid?

KG: The lack of health insurance for the poor.

I: So it was altruistic?

KG: This was the Johnson administration.

I: Say no more.

KG: Prior to that there had been medical systems for the aged through Title 12 or something. But this was the Johnson administration and Medicare and Medicaid really wanted, so that they wouldn't go to universal health insurance, to cover those areas where people were most in need. They gradually extended it. Senator Long was also the one who got through the coverage for kidney dialysis. He had a relative. He was the one who got through the stuff. He was the kingpin on the senate finance committee.

I: Did he have someone in his family who had retardation?

KG: I don't know whether he did or not. I think he may have but it was fairly distant probably.

I: So that was part of the great society?

KG: Yes. You want to know how policy was developed? Policy often sprang from several different sources. Local policy might spring from federal policy like Medicare and Medicaid. Those weren't anything we originated. We said, here it is, we have to run with it. In a minute I will tell you how the whole entire drug abuse policy developed in the state from one Wednesday afternoon conference. It originated from the legislature. More often than not, even though there were advisory committees and so forth around, most of the policy and implementation issues stemmed from the staff. That is different than it is today perhAPAs.

I: At the hospitals?

KG: At the department level, the mental health division level.

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I: The program planning?

KG: Yes. That originated with the staff by and large. You had to run it by certain advisory committees that you had but it was strange. There was a mental health advisory committee or board and I can hardly remember any of the meetings because they weren't that important.

I: I'm on the committee now.

KG: I know you are. I know what they are like now but then they just didn't seem to have much impact. You bounced things off of them but they very seldom originated anything. In the field of mental retardation there were a very small number of people that were organized in terms of the families of the mentally retarded. Generally they wanted their plan for the Oregon Health Plan and I had to write it for them. They couldn't write it. They had no staff. I wrote their plan. A lot of these things had to come from the professional, technical staffs. When I became administrator of the staff at the mental health division it consisted of sixteen people. We were officed in the basement of the State CAPAitol.

I: At least you were close to the lawmakers.

KG: Yes but we had another very important thing in those days. These little things that make a difference, for example, my secretary had been a secretary to the legislative fiscal committee. She knew the legislature and she taught Joe Trelevan and me and Ray an awful lot about the legislature that she knew from the inside as their secretary. She would tell us how to write things, how to present things.

I: I hope you paid her well.

KG: She was a Secretary 5. I fired her once and hired her back two days later. She was obsessive-compulsive but she was great. There were several things that came along. Let me show you what these are now.

I: Mental Health Division Programs 1969.

KG: On Page 9 we had called for improvements in basic patient care, improvements in the aide and nurse staffing in wards. We had done a preliminary scope survey which had given us some information. Scope was staffing care of patients effectively that had been originated in the State of California. We had adAPAted it in Oregon and done some preliminary studies and wanted to use it as a basis for staffing. We also wanted to do some operational research. We wanted to see what would hAPApn if we did improve staffing. They were still pretty new with the services. This is what we requested in terms of additional money per institutional budget, \$177,463. This is recommended for implementation with three biennium in six years. We thought it would help patient comfort and improve patient adjustment and enhance the moral of patients and staff. Scope with the first two surveys was a method of going out and measuring the amount of nursing personal patient care each patient needed on a questionnaire that could be completed with each patient in six minutes. We surveyed all the patients in institutions. They had a way of handling it statistically so you could come up with, if you are going to meet these

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needs you need this many nurses, this many aides, this distribution of staff. California had brought it and it was based on industrial engineering studies that California had funded. We decided that was the most rational thing we had heard of so we developed the scope of things. It is interesting, the fella who, we advertised for the position through the personnel department, in the personnel department who reviewed the position said it was too high a salary and downgraded the salary. Two weeks later he decided it was such an interesting position he wanted it.

I: Did he upgrade the salary then?

KG: He couldn't. He stayed with us until I moved to Ohio. I finally moved to Ohio to do Scope development in Ohio and subsequently ran a million and a quarter research grant program in Ohio. Subsequently he went to and still works for, Federal Express. He is the fellow who designed the system by which Federal Express distributes its packages and flies into Memphis every night.

I: You never know how something is going to go, do you?

KG: No. Last I heard he was still there. He did such things; he was very creative, as they used a lot of part time students to sort the packages in the middle of the night. He throws in an occasional random twenty-dollar bill. He is also the one that came up with the idea of a hand held computer for Federal Express and some of the other companies. He is the Scope guy.

I: I couldn't find any information really about how Scope started. What you have just told me is very helpful.

KG: That came from us. We knew we had management problems.

I: It sounds like you couldn't meet the APA standards?

KG: The APA standards were primitive. They weren't based on anything other than guesses and by gods.

I: The other thing I ran across was it was hard to get staff because the salaries were so low particularly for psychiatrists.

KG: Yes. That has always been true. That isn't unusual now or then.

I: All the way through as I was reading, there is constant comments related to that.

KG: People in state government always say that.

I: I'm not getting paid enough?

KG: Yes. Teachers aren't getting paid enough.



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I: I'll put it in a different context.

KG: They always do that.

I: During your tenure they offered to dissolve the board of control.

KG: That happened in 1969. It was established in 1913 and ran each institution separately until the mental health division was created. Then they created the corrections division and subsequently created the special schools division. That was with a secretary who was the chief executive officer of the ward, Nick Pete had been that for a while. The last one when I was there was Carl Hogarud. The secretary had a lot of financial management capabilities. The governor obviously wanted to develop the power toward the governor's office. He had introduced a bill to create the department of human resources. Along about that time, they had a prison riot in the spring of '69. It was a pretty bad riot and several people were killed. The warden was in Seattle in the hospital being treated for cancer. They hadn't named a successor or an alternate and it got out of hand. It happened on a Saturday. I was living up here at the time. We heard it on the TV and called down there. It was a pretty disastrous riot. The board took twenty-four hours before they put anybody in charge of the prison and they really lost control. That was one of things that really got them. There were a couple of other things.

I: Public opinion?

KG: Public opinion. They were very upset. They had all sorts of interesting things. They had put all the entire laundry facilities for all the institutions in the prison and they burned it.

I: The prisoners burned it?

KG: Yes. They had no place to do the laundry.

I: That would cause problems.

KG: They went up to Fairview Hospital and Training Center to do laundry. There wasn't a commercial laundry in the state of Oregon big enough to take the mental health division laundry. We opened up the Fairview laundry again and put the retarded patients back to work. We had to make the meals at Oregon City hospital and send them over to the prison.

I: Because they had burned the kitchen as well?

KG: You couldn't get in. I don't know how much damage was done but for awhile meals had to come out of OSH. Then they did a thing where the administration of the OSH rolled encumbrances under the desk at the state hospital, \$144,000.

I: Was that the scandal about the Christmas party and all that?

KG: No. That was later on. That was about alcohol in the unit with George Sukow.

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I: I'll have to ask him about that.

KG: I don't remember much about that. There was a scandal when the chief administrative officer under Dean Brooks got the hospital \$144,000 in debt by failing to pay the bills.

I: Did he have the money?

KG: No. He didn't tell anybody. He hid the bills. That came out and it was a big brouhaha. I wanted to fire Dean Brooks and they wouldn't let me and they were right. We had to cut back on all travel and stop hiring people and recoup the money. Of course he got fired. There were several things like that. It was just like the Board of Control wasn't paying attention to the job. The governor had his bill in for the creation of the department of human resources. That was what he was pushing. When Marko came up and leaned over and whispered to Governor McCall, he looked up at the other two fellows, Straub and what was the other one, and said, Gentlemen, we have been abolished, right in the middle of the meeting. We all knew the senate was debating the bill. We all had our ears to the ground. We were like anybody else when you are responsible for something you like to have the responsibility instead of depending on somebody else.

I: The governor wanted the responsibility and he wanted to delegate it to the department of human resources?

KG: Yes.

I: Also I understand that the three members had equal votes so the other two could vote down the governor.

KG: Right.

I: If I were the governor I would not particularly APApreciate that.

KG: Right. He wanted to create the department but it was not actually created until 1971. The board was abolished in 1969. The mental health division, the corrections division, the division of special schools became separate departments although they were called divisions. They were in fact, independent departments for two years before the department of human resources was created in 1971. We were allocated certain functions then that had previously been at the secretary of the board and allowed to proceed as independent people responsible to the governor directly.

I: So each of you was responsible directly to the governor?

KG: Yes.

I: How did that work?

KG: It worked like it did most other places. The governor doesn't get involved in operations unless it is politically difficult. If you do your job that is all they want. McCall was different because McCall was very interested in alcohol and drug programs. He was very instrumental in pushing those while particularly during the period of time in that two years. Let me back track a moment and I will tell you what hAPApended to the alcohol and drug program in the state. It must have been in the session in 1967, the budget session of 1967.

I: We are talking about the creation of the new program for public education and information on narcotics, habit forming drugs and hallucinogenic drugs.

KG: Right. This hAPApended on a Wednesday afternoon in the spring of 1967 when the fellow who was then heading, George Dimas was his name, the alcohol and drug section of the mental health division. He and I were testifying. We had asked for \$17,000 additional budget in the next biennium for some new information books on drugs. The legislators sat there and looked at us. They said, what is going on here? We said, we read in the pAPAer that there was a bust in Portland of a bunch of young people using drugs. Our friend, the mayor of Springfield, Oregon, died in a motel room last Saturday night of an overdose of barbiturates and drugs. We think there is a big problem here. It came right from there. That is where the policy originated.

I: From those two incidences?

KG: Yes and from a legislative Ways and Means Committee. They said, we want to do something about this. We will read your books. Come back tomorrow and tell us what we should do. George and I didn't have anything in our books. I had a complete library but I didn't have anything on drugs. We came back and said, we don't know, there is nothing in our books. They said, we would like a statewide program. This was Thursday. Come back tomorrow morning, Friday, with a budget for a statewide program on drug education including a curriculum guide for the public schools. We came back with a request for \$173,000. That's it? You don't need anymore? That is all we can deal with right now. We wrote the first curriculum guide for the public schools. I personally proofread it. We hired some people, some teachers and some other people who wrote a curriculum guide. I've lost it now but it was about that thick. It was the first one ever published in Oregon. From that it just zoomed. The governor got very interested. He had some problems in his family so he had some personal interest in what was going on. He promoted all the things we were doing. We went out and got grants for this. One time we went to the emergency board and wanted to have a special program. I don't even remember what it was but you had to go to the emergency board. We wanted a grant from the emergency board to start an inpatient program for hard core narcotics addicts. They said, this was Thursday, we think you ought to be able to get that from the federal government. Why don't you write a grant request and send it to the federal government. From Thursday afternoon until Sunday night, the staff wrote a grant request for a quarter of a million dollars. The governor personally took it to Washington on Monday. Tuesday he came back with a grant. Things like that were going on and you could just get all sorts of money. They sent me on a tour through California to visit a lot of drug programs and some of the people who were doing research on LSD and other things down there. They wanted to find out what it was about. That eventually developed over the years and you will find that subsequent to this in the next volume.

I: We are talking about this bill, the amendment to the public intoxication statute?

KG: I've forgotten exactly which one it was but we had a bill I think in the '71 legislative session where we called it the "five and dime" bill. It would tax alcohol sales a nickel a pint and a dime a quart. We had it authorized and all that money went for public education information and treatment of alcoholism. It came pretty close to getting passed. After that, in the next biennium, they gave us more money. In '69 they wanted to do this. We added beds in the state institutions. We developed seven halfway houses for alcoholics. We had a regional program for public information with field offices. We had the methadone maintenance program contract to provide treatment and after care facilities for narcotic addicts from the federal government. We had a federal grant for use dependent program. We had a federal grant for alcoholic and traffic safety. All sorts of things were going on that all came out of that Wednesday afternoon.

I: Isn't that amazing.

KG: Plus the governor. He and I did mutual television things together and mutually signed letters all over about some of the governors interests. He was very close on that issue.

I: It shows you what a person can do in power if they are interested.

KG: Yes. He was marvelous. Have you read his biogrAPHy?

I: Not yet.

KG: I haven't read it yet either but I'm going to. There are several other things that hAPApended during this period. I told you about Medicaid for the retarded in the institutions. Then there were two programs, one for trainable retarded and one for emotionally disturbed children that were key programs we were trying to get going. The program for the trainable retarded was based on the fact that we had public institutions and the higher level, so called educable retarded, were being educated in public schools. There are a vast mass of people out there who are sort of in between needing institutions and being able to participate in special ed classes. Nobody was serving them. I think it was the '67 legislative session, put together, or maybe it was even before that, I guess it was before that under Joe Trelevan. They put together a kind of pilot study of the trainable retarded. We followed up and did research on this thing. We read all the literature and actually developed a pilot school here in Portland that we ran for a couple of years to get some experience in how to deal with the trainable retarded. During this period we did start this program for the trainable retarded and contracted to provide those services in the public schools with funds out of the mental health division. The department of education didn't want it and they subsequently took that over. There was another couple of important things. There was a program for emotionally disturbed children. That was kind of an unfortunate thing that hAPApended. In 1969 we started this development from the legislature where we would do this intensive program of children in the community who needed care and treatment who were quite young. We were also developing adolescent programs at Dammasch and at OSH that would at least provide some treatment services for adolescents in hospital with no outpatient services. We developed a contract with Edgefield Lodge where they would care for five kids at any time in kind of a halfway house arrangement that we had also developed up

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there. I think there were about sixty-three children who passed through that program. In the mental health division we had a team of three social workers and a psychologist who went around and went out into the community and assesses a child. If the child were authorized they would put them on a waiting list and bring that into a special program. There were children who were twelve and under.

I: Prior to their going to Edgefield Lodge would they be in their homes?

KG: Yes.

I: And the parents would just have to deal with them?

KG: They would be at school, home or someplace.

I: Were the clinics in operation at this time or not?

KG: Yes but we were talking about the severely emotionally who couldn't even be handled in an outpatient setting. These were children who were beyond the pale of counseling.

I: Off the wall?

KG: Yes, very sick kids. We ran that for approximately two years. We presented the next legislative session in 1971 a proposal for a children's treatment program. If you look at the division's 1971 budget request you will find a considerable discussion of that.

I: We are talking about the recommendations for the children's program.

KG: This is the recommendation developed in 69 and 71 for child treatment program based upon day treatment programs, foster homes, and small group homes. The only inpatient service being contracted at the medical school just for diagnostic and stabilization. It would otherwise be a non-institutional program. It was APAproved by the legislature. We also had to ask for an additional doctor on the staff at Dammasch State Hospital. The medical school residency program under Doctor Sazlow who is a good friend of mine, had not had enough residents to be able to assign the residents we were supposed to assign to Dammasch State Hospital. This made the members of the Ways and Means Committee mad. Now they had to come up with more money for doctors at Dammasch. The president of the senate called me and the Dean of the medical school in. He said, I am tired of this. I want you two to get together and develop a joint residency-training program between the medical school and the state that will give these doctors experience in community mental health programs. I said, fine. The Dean said, of course. I will leave with you with that and turn you over to Don Bray. Don Bray will pick you up how that developed. The president of the senate said, when you return I want that child in the mental health treatment program transferred to the new children's division out of the mental health division. I want a unified children's program. Who is going to argue about that? The fact of the matter is that it failed completely the next year and they threw it out and quit. If it had stayed in the mental health division it would have worked but Don Bray and the people in the division

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were intimately involved and all of our staff people. We had all the connections and we had done all the work but they politically moved it and killed it. It was way ahead of its time.

I: When was the children's division created?

KG: With the department of human resources in 1971.

I: So just moving it.

KG: Yes. They didn't know what to do with it. They didn't have the experience, didn't have the contacts, didn't have the staff, and didn't have the history. It was too bad. It should have stayed with the mental health division.

I: Well that takes care of that one doesn't it. I remember reading about it and then nothing hAPApended but you don't know why nothing hAPApended?

KG: I know why nothing hAPApended.

I: Yes. Now I know why nothing hAPApended.

KG: You won't find it anyplace except where it is sort of written to explain why you want a budget request. You are welcome to use these but they are my only copies.

I: I will return them.

KG: Either that or they need to be in the archives of the division. Community mental health programs. The community health program had come in and there was gradually standing depending on the availability of resources and people. It was still when I left in 1971, pretty much of a rudimentary program but it takes time to grow community programs. When I left in 1971, we had proposed, Don Bray and I, a massive change and reorientation of the community mental health programs which you will find outlined in here.

I: Is that the creation of the three divisions?

KG: I don't remember exactly whether that was when the organizational changes may have occurred. Basically we wanted to create some regional offices and regional responsibilities. That all occurred after I left. Don Bray can tell you but the plan is in here.

I: I have read that.

KG: He will have to tell you what hAPApended.

I: Lets talk about the Department of Human Resources.

KG: I think it was another big change when Governor McCall wanted to develop the department of human resources. It brought what was then an independent mental health division

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into a different department. Basically what he wanted to do with his bill was have a massive single bureaucracy with everybody subject to the director of human resources and a centralized operation. Some of us, who were the administrators of the divisions, had qualms about that. They were personal qualms because we didn't want to lose our autonomy. We also had qualms about whether that would work in the state of Oregon. I volunteered to give testimony questioning the Governor's plan. I have a copy of that testimony which is really kind of classic which I will give to you. The interesting thing about this is that I gave this one day before the subcommittee governmental reorganization of the house of federal affairs.

I: What year is this now?

KG: February, 1971. It was debated on the floor the next day. The proponents quoted part of this and the opponents quoted the other part because I tried to lay out the issues and the problems. They passed the governor's bill intact. It went to the senate. When it got to the senate I told some senator friends that I was really concerned that it was too centralized an organization and could I give some more testimony. I gave this testimony also to the senate. The senate changed it along the ideas of this testimony. The governor said, what is my mental health director doing opposing my bill? But he was never the kind of person who would fire you for something like that. I had already resigned and was accepting a position in Ohio so I was free to do it.

I: Why did you choose to resign?

KG: I had an offer from Ohio to head the department of mental hygiene and correction, a bigger state.

I: A bigger job and a bigger state.

KG: Yes. I had the prisons, parole probation, seventeen mental hospitals, ten institutions for the mentally retarded, the entire statewide drug abuse program, the entire statewide geriatric program, three APAartment houses for the aged, and nineteen thousand acres of farmland.

I: A kingdom.

KG: Yes, it was a kingdom. Fourteen million square feet of floor space. That was a big operation in those days. This was the last of the kingdoms. They pretty much disappeared about that time. We had houses for the superintendents that had twenty-seven rooms in them.

I: Did you have that house?

KG: No. I had my own house. I wasn't provided a house. I was in Texas. It was very nice but not an unusual house.

I: Did you have a house on the grounds?

KG: In Texas?

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I: No, here.

KG: Only when I was a resident on the staff earlier.

I: When did they stop doing that?

KG: When I came to the hospital in 1953, you got a house and all the furniture, linens and all food. They found that there was considerable abuse of that food. For example, there was the story of the woman doctor who ordered six hams to take to her Sunday social and that sort of thing. The other people who had ordered twelve dozen eggs to make into deviled eggs for some social event. What they did was they stopped doing that and increased everybody's salary by \$125 a month.

I: With the housing and everything at least you wouldn't starve.

KG: No. That wasn't so much money forty-six years ago. It had to be in about 1954 or 55 when they did that. They stopped the food draw. Then they provided a house and then they just gradually stopped. At one time, the mental health division was the largest renter in the state of Oregon. We had seven hundred rental units.

I: For the patients?

KG: No, for the staff. ✓

I: For the staff on the grounds? I didn't understand that people had to pay for that.

KG: Yes.

I: Interesting.

KG: Superintendents didn't but other people had to rent. We were the largest real estate renter in the state of Oregon. I had a whole special report on it if you are interested in that.

I: I would be interested.

KG: Beginning in 1971, Don Bray and I proposed making a general pay raise statement on the health program. We had a management company task force. We came up with a lot of recommendations. We proposed a mental health service carry community programs, area clinics. This was in 1971. I can't tell you about what hAPApended with this because I was leaving and Don Bray was taking over. This hAPApens to be the whole plan.

I: Thank you.

KG: Don Bray may or may not have that but that outlines that.

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I: We are talking about the scope material.

KG: Yes. We went to the emergency board and said what we wanted to do based on our scope studies was add staffing in different patterns and different institutions and measure the outcomes. They gave us the money to do it and then we had to report back. What we found was that it didn't much good to add staff unless it was used in a way that it was directly related to patient care. For example, at OSH they added a ward clerk in order to relieve the nurses. They found out what the nurses did and they just involved themselves in more pAPAerwork.

I: You mean with the administrator there? Say that again.

KG: They put in a ward clerk to handle the pAPAerwork on the theory that the nurses would spend more time with patients. The outcome was that the nurses still found more ways to spend their time with pAPAerwork.

I: Amazing.

KG: They added some staff at EOH. They could never measure the results or the outcome. At Fairview where they added staff they specifically dealt with developing life's basic training skills, tangible results can be shown.

I: Probably depended on the people too didn't it?

KG: It depended on a lot of factors but all the discussion is in there. The fact is that the legislature was willing to give us money to do operational research on staffing which is kind of amazing.

I: Did you find them basically responsive to the needs?

KG: Yes, within the limits of the money. Sometimes they got into trouble. For example, when the child development rehabilitation center at the medical school was authorized, they had to have a federal grant and they needed federal and state matching money. As a result of that they had to delay one of the programs. I think it was the program for the trainable retarded for a year or so because they needed the money for that. After they got the thing constructed they found out that the children's bureau which had promised staffing money would not provide the staffing money. By executive order, they reached into every department and had to come up with a certain amount of money to run the thing at the medical school which made us all a little peeved. Nevertheless I was at the dedication and wrote a poem for the dedication. They were quite responsive. If it was a dumb idea they could generally shoot it down. I have heard them shoot down some dumb ideas. Legislators can be pretty darn smart. I remember at one emergency board meeting somebody from the health department wanted x millions of dollars to do a certain kind of testing for syphilis. They said, how many tests have you done in the last year? X number of tests. How many cases of syphilis did you detect? Was that a communicable case? No. Why do you need more money? We had Don Bray who was the assistant under me and we had a track record. Only once did we ever lose a request to the emergency board. They

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were that responsive. If you went with a request that was well documented for a reasonable thing and I think there was only one where they said, go get federal money.

I: That is very good.

KG: We had a very good track record with them. They were very responsive.

I: Let me ask you one final question. What are you most proud of?

KG: Making a rational administrative process out of a chaotic agency. That was true many other places that I worked. I am no expert at programs.

I: Sounds like you are a good administrator.

KG: You have to provide good administration and that is what I am most proud of.

I: That is good. Thank you.