

EI-280

DR. JAMES LOUIS BAKER

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**PSYCHIATRIST AT ELLIS ISLAND
1949-1951**

Oral Historian's Note: Dr. Baker is the father of William Baker, Interview EI-035. Paul E. Sigrist, Jr., Director of the Oral History Project, 5/9/1994.

LEVINE: This is Janet Levine for the National Park Service, and I'm here today with Dr. James Louis Baker at his home in Punta Gorda, Florida. It's April 16, 1993. Dr. Baker, his first stay on Ellis Island, or his first work on Ellis Island, was when he was stationed there for three months in 1942 as part of his psychiatric residency training. He then returned as Director of the Neuropsychiatric Service on Ellis Island and was there from November 1949 until March or May of '51.

BAKER: I think it's, I think I've established it, it was

March of . . .

LEVINE: '51.

BAKER: Of '51, March 7th.

LEVINE: Okay. (she laughs) So, that is, by way of introduction, and I just want to say I'm very happy to talk with you. I've looked forward to this for a long time.

BAKER: Well, I appreciate you coming down here and taking all the trouble to interview me.

LEVINE: Okay. Why don't we start at the very beginning by your just telling me your birth date and where you were born.

BAKER: Well, I was born in Louistown, Pennsylvania on April 16th. This is my birthday . . .

LEVINE: Oh, happy birthday!

BAKER: In 1914. At the time, my mother and father were living in Louistown. He was a native Virginian, and she was, had been born and raised in the Louistown area. Accordingly, I was very close with my grandparents, and so when we were living in Richmond,

Virginia, when I was seven and my father was killed in an accident, it was only natural that I'd go back to my grandparents' home in Louistown.

LEVINE: I see. Tell me your grandparents' names.

BAKER: My grandfather was William M. Miller, and my grandmother was Ida, Ida Mae Miller, alias Dipple. Her previous maiden name was Dipple.

LEVINE: How do you spell it?

BAKER: D-I-P-P-L-E.

LEVINE: Just because you worked on Ellis Island, where did your roots come from originally?

BAKER: Uh, well, I grew up. My, after my father died I grew up and went to high school in Louistown and graduated from Louistown High School, I was registered for aeronautical engineering at Pitt, pre-dent at Penn, Pennsylvania State College. I was registered for chemical engineering, and I ended up going out to Texas and going to none of them. I ended up going to Amarillo Junior College it was then. It's since become a full-time, a full four-year school, and lived with, I always called him "uncle," but he was really

just a second cousin. In Amarillo, Texas. I ended up completing two trimesters of school there, but I got the wanderlust, quit school after the first trimester, or second trimester, and headed out to the west coast via Denver because we had an automobile delivery that was going up to Denver and so we went up to Denver. And then later a friend went with me, and we were, we stayed up in Denver about a week visiting some relatives of his. And then left for the West Coast on a car driving expedition where they were taking used cars out to the West Coast from the Denver area, and we drove one of the, each of us drove one of the cars.

LEVINE: This is you and your cousin.

BAKER: No, no. This is, uh, he was just a friend. His name was Mickey Smyres, uh, S-M-Y-R-E-S, I think. So we ended up in Los Angeles.

LEVINE: What determined you going to medical school?

BAKER: I had always been interested in medicine, and I decided when I was in college that that's probably where I was going to end up, and after I settled down a bit, why, I went to the University of Florida, just transferred my credits down from Amarillo. I went to

the University of Florida because I fully expected my wife to be going to school either there or up at the Florida State at Tallahassee. She ended up going to the University of Missouri, but that's another story.
(they laugh)

LEVINE: Well, tell me how you, just jumping a little bit to your residency. How did you decide to go to Ellis Island, or were you chosen, or . . .

BAKER: Well, I was, at that time I was sent for preliminary psychiatric training and evaluation up to Chillicothe, Ohio to the Federal Correctional Institution there. I knew I was only going to be there a short time, but this was kind of the service's idea of evaluating my psychiatric aptitude.

LEVINE: Now, were you in the service? Is that how you . . .

BAKER: Yes, I was always in the service. I interned in the service and, the United States Public Health Service. I interned at New Orleans in the service, and was sent over to the quarantine station there as my first active tour of duty. That was over at Algiers, Louisiana. I knew I was only going to be there a short time, and that's, I was transferred from there

up to Chillicothe, Ohio.

LEVINE: Let me ask a naive question. This was wartime when you were doing your . . .

BAKER: It wasn't wartime yet. December 7th we were looking for a house in Chillicothe, Ohio and, when we heard that the Japanese had bombed Pearl Harbor and heard we were at war. In fact, I remember it very well. We got the information when we drove into a filling station to get gas. And, of course, that was all the topic of conversation then, because it had come over the radio, and found out we were at war.

LEVINE: Were you in the Public Health Service because Europe was at war? Is that why you were doing that at that time?

BAKER: No, no, no. The United States Public Health Service historically became, it's a commissioned uniformed service. And historically they have been part of the armed forces in time of war. And sure enough, it happened this time, too. The public health service is made up, or was made up at that time of a hospital division, a state's relationship division, a quarantine division. And that was back when they

first started the Institutes of Health, the National Institutes of Health. I believe those were the main divisions of the Public Health Service at that time.

LEVINE: Did you plan to be working with the government in your career?

BAKER: Well, I had an uncle, in fact, I had two uncles that were in the service. Both were dental officers. I knew that high-quality medicine was practiced in the service, and it appealed to me as a career, and I made it my career. As I said, I interned at the Marine Hospital in New Orleans, as it was then called. It since was renamed the United States Public Health Service Hospital, but the natives in New Orleans still referred to it as Marine Hospital.

LEVINE: Do you remember, putting yourself back at that time of your internship in New Orleans, do you remember applying for your residency at Ellis Island, or what was that all about?

BAKER: Well, I had, from Chillicothe I had applied for residency training right from the very start, and I was approved for residency training in psychiatry while I was in Chillicothe, and then I was transferred

to our psychiatric hospital in Fort Worth, Texas for residency training, and I had my first year of training at the Fort Worth Hospital. Then along came the need for people in aviation medicine, and I went back to my earlier interest in aeronautical engineering (he laughs) and applied for flight surgeon's training, and was sent down to Pensacola for training as a flight surgeon. And you weren't exactly, you went to the School of Aviation Medicine, which gave you an AME, Aviation Medical Examiner, but I was selected along with the top ten percent of the class to be, for flight surgeon's training. So we went from the School of Aviation Medicine over to the, I forget, I think it was Chevalier Field, but that doesn't matter.

LEVINE: In Florida?

BAKER: Yes. It was right there on the main side base at Pensacola.

LEVINE: So you had completed some internship in psychiatry.

BAKER: No, you don't intern in psychiatry. You have a general internship.

LEVINE: I see, I see.

BAKER: And then you go into psychiatry. So I broke up, I broke out of psychiatry to become a flight surgeon, which I did, and was accordingly transferred up to the Coast Guard Air Station. We are the medical corp for the Coast Guard. I forgot that as another division of the service, but I was transferred up to the United States Coast Guard Air Station, and . . .

LEVINE: Where was that, where you were transferred?

BAKER: Floyd Bennett Field. That, I don't know whether the field's still there or not.

LEVINE: It's now also maintained by the National Park Service.

BAKER: Oh, Floyd Bennett is?

LEVINE: Yes. And I've been told they're starting an Oral History Project, so you may be going to do that as well. (they laugh)

BAKER: Yes. Because I ended up, I had already soloed the helicopter when they decided that they had no authority for me to be flying a helicopter. So I put in a study suggestion that the helicopter needed at

that time a study of the control configurations and instrument placement in relation to pilot safety. It went through channels, which was down to, at that time the Coast Guard was under the Navy, so it went down through channels to the old Department of Research and Inventions. And it was rapidly approved. In fact, in about two weeks the Coast Guard ordered me for, to complete helicopter pilot training. All I needed to do was check-out with the instructor because I'd already soloed it, so he gave me a check-out flight and designated me a helicopter pilot. So I could have worn either the flight surgeon wings or the regular wings, but I stuck with my medical background and wore the flight surgeon's wing, because you can't wear both. So . . .

LEVINE: What year was this? Do you remember, roughly, when you were at Floyd Bennett Field?

BAKER: It was 1940, '41 I was transferred up there, December 6th, and I was there until, I was there until, the war ended in Europe, VE Day, VJ Day, I forget exactly, but I was there most of '46.

LEVINE: Uh-huh. Well, now, let's see. You did your residency

for three months in '42, right?

BAKER: Yes.

LEVINE: So you must have left Floyd Bennett Field . . .

BAKER: (he pauses) Yeah. What did you start to say?

LEVINE: You must have left Floyd Bennett Field for three months anyway, while you were at Ellis Island.

BAKER: No, no, no. That was before, '42.

LEVINE: Okay.

BAKER: '42 was before that.

LEVINE: So you had done your residency, then, before . . .

BAKER: Yes. I, I was actually stationed at Fort Worth on three different occasions, but I get them mixed up. But the Ellis Island transfer was from Chila, wait, I was wrong. The Ellis Island transfer was from Chillicothe to, for three months of residency training on Ellis Island, and then the additional rest of the year was up at Psychiatric Institute, New York Psychiatric Institute. And then I was sent to Milan, Michigan to do a psychiatric study on Jehovah's

Witnesses. And, uh . . .

LEVINE: Can you say what decided you to go into psychiatry?

BAKER: I thought it was an interesting field. When I completed my internship I was approached for a possible surgical residency. I was approached for and probed for my interest in a state's relations type of career, and I just selected psychiatry thinking it would be the best field to enter and the most interesting.

LEVINE: Could you say a little bit about how psychiatry was at that time as compared with now?

BAKER: At that time the first drug was this rauwolfia, the alkaloid, gee, I can't remember the name of it now, reserpine. That was one of the first drugs, psychoactive drugs. Later came Thorazine. And Smith, Kline and French selected the hospital in Fort Worth to be one of the original places that Thorazine effectiveness would be evaluated. So up till then we had psychotherapy. We had no psychoactive drugs. We had shock treatment, which was really even then in its infancy. And that was about it. As I say, we were one of the first hospitals to study Thorazine's

effectiveness, but we at Fort Worth, we, I'm referring to the United States Public Health Service. At Fort Worth we were kind of, initially we got all navy psychiatric cases that didn't respond to shorter-term treatments. Then we became, St. Yves was used for East Coast psychiatric cases, which there were very few, because at that time the war was in the Pacific.

And we were the end place for navy psychiatric cases from the West Coast that didn't respond to briefer treatments. In fact, they were so swamped at that time that if it had a longer term diagnosis, the prognosis indicated a longer term treatment, they were transferred to Fort Worth. They used to bring them in by the trainload full, run right into the siding at the hospital.

LEVINE: So you were on the forefront as a pioneer of Thorazine, the use of Thorazine.

BAKER: Yes.

LEVINE: Can you say what it was about Thorazine that struck everybody at that initial time?

BAKER: Well, Thorazine, which was Smith, Kline and French's trade name for the drug, but they discovered it, it

was really the first, except for this reserpine that I mentioned, it was the first drug that you could demonstrate had therapeutic benefits for the psychiatric patient, particularly the psychoses, of which schizophrenias predominated. So after that, all the drug houses got to studying psychoactive drugs and many of them were originally offshoots of Thorazine. Then we came around to the tricyclic antidepressants.

LEVINE: That was some time later, wasn't it?

BAKER: That was much later.

LEVINE: Yeah. What was the difference between Thorazine and the reserpine?

BAKER: They were, reserpine had many side-effects, and it wasn't as effective as Thorazine, so it was dropped early.

LEVINE: When you say effective, what specifically do you mean?

BAKER: Effective in, well, at Fort Worth, for example, we were able to discharge to their home eighty percent of patients as being markedly improved or recovered with a combination of shock therapy and Thorazine.

LEVINE: Well, now, shock therapy was in its infancy.

BAKER: Well . . .

LEVINE: How . . .

BAKER: It was being widely used at that time. We would have scheduled for shock treatments a hundred patients a day. And believe me, it was a very effective method of treating schizophrenia. In fact, it was the only method we had at that time that proved effective. Insulin therapy was much more dangerous.

LEVINE: What was the danger of the insulin?

BAKER: Comas and untoward reactions in the way of controlling the treatment therapies. You never knew what sort of effect you were going to get when the, until you gave the patient the insulin treatment. But it was practically the only drug treatment of, I forgot about insulin. That was the only drug treatment for many years. I say many years. In psychiatry maybe it was ten years.

LEVINE: Well, what was the insulin used for, what group of patients?

BAKER: Mainly they were schizophrenics that didn't respond to other treatments. And we used to have, up at New York Psychiatric Institute, we had thirty-some patients there that would be on insulin therapy. In fact, the whole ward was devoted to that treatment, and it wasn't without danger. In fact, when I was there, two people died from the results of insulin therapy. Most of those were very sick schizophrenics, but the families didn't take to it any better than . . .

LEVINE: No. What would the insulin do, physically, to kill somebody?

BAKER: It produces a insulin coma. It's an altered consciousness that seemed to be beneficial. Only we didn't exactly know why it was working, but I don't remember how it was discovered. I think that an Italian was the first to demonstrate its effectiveness.

END OF SIDE ONE, TAPE ONE

BEGINNING OF SIDE TWO, TAPE ONE

LEVINE: If you gave insulin therapy, the patient would go into a coma and that altered state was therapeutic to them.

BAKER: Yes.

LEVINE: Would they stay in it for a very long time?

BAKER: Uh, not more than an hour, and it would be terminated.

But they didn't always respond. Most of them responded rapidly to the termination by injecting glucose. But not all of them did.

LEVINE: Then they would stay in that coma.

BAKER: It would be a prolonged coma, and that would be a complication of insulin therapy. So I don't think insulin is used any more.

LEVINE: I don't either. What about the electroshock as compared with the insulin? When would a patient get that?

BAKER: Well, electric, electric shock proved much more effective than insulin therapy, and a lot of people since have gotten mixed up on the fact that electric shock therapy is punitive. That's ridiculous. We also pioneered with another drug company the intercostrine, which was a curare-like preparation, which minimized the muscle, the convulsive part of the seizure to where it was a minimal convulsion. In

fact, often it amounted to no more than slight movement of the mouth, and just a bare movement of the extremities. But, so that reduced the complication of severe contractions, because they can produce fractures at times.

LEVINE: This is with the electroshock.

BAKER: Yeah, before the intercostrine. But also you have to almost titrate the effects of the intercostrine, because it seemed to vary from day to day and from patient to patient as how much you needed to give to get the desired curare effect.

LEVINE: Now, what would the curare do? It would simply work on the nervous system without the muscular system being involved?

BAKER: Curare is a, it has the effect of paralyzing the muscle system. It can be deadly but we didn't use anything like deadly doses. We just used it in doses that would minimize the muscle contractions that came on with the shocks. So we would give, we would give the patient an injection of intercostrine, which was what the trade name of the curare-like drug I'm referring to, and then administer the shock. And we

found that there was an optimum period between giving the intercostrine and the minimizing the effects of the, I think we usually waited a full ten seconds and then gave the shock, although it would vary because some days it would seem to be more effective. Maybe it was, I don't know what it was, but fifteen minutes, and other times it would be, not fifteen minutes, fifteen seconds. And other times it would seem to have its desired effect in a briefer time, like six to eight seconds.

LEVINE: Now, how would you know? How would you determine whether it had the desired effect?

BAKER: We could only determine it by observation. We'd start out with giving a standard dose and then we would vary that, depending on what we saw in the patients as we treated them.

LEVINE: So if you saw slight muscle twitching in the extremities that would be . . .

BAKER: That would be a desired effect. If it would too flaccid, that was probably getting a little too deep, too much curare effect, and sometimes the treatment wouldn't be effective, or we couldn't tell whether the

treatment was effective, because we wouldn't get a recognizable seizure. But, so we just had to play it by ear.

LEVINE: Were you using the curare and the electroshock at Ellis Island?

BAKER: We had them. We were using, yeah. We had quite a, when I was in my first three months of residency there back in '42, we had quite a lengthy shock line. And we didn't have the curare at that time, the curare-like drug. And . . .

LEVINE: Isn't curare some kind of a Mexican, um . . .

BAKER: No. It's, curare is used by, I think it was, I think it was first used by an Aborigine tribe.

LEVINE: It's a plant that has that paralytic effect.

BAKER: Yes. And they made a crude extraction of curare to use in their poisonous arrows, and at that dosage it killed the people that were hit. But we didn't have the intercostrine to minimize the convulsive effect in '42 when I was back at Ellis Island, but we were widely using it.

LEVINE: Were you using it mainly for schizophrenic patients?

BAKER: Yes, and depressions, acute depressions. And it was very effective in acute depressions. But . . .

LEVINE: What about a catatonic patient? Would you use it on someone like that?

BAKER: Well, catatonia is a variety of schizophrenic, schizophrenia. Often, there was a condition called catatonic excitement where they would get into a frenzy of activity. Prior to shock treatment, the only thing you could do was put them in sedative water packs and hope. Many of them would die in this catatonic excitement, because their temperature would just keep shooting up. The body got to where it could not maintain temperature regulations. And the temperature would shoot up to a hundred and five, a hundred and six or a hundred and seven, and the patient would just expire.

LEVINE: What were the sedative water packs? Were they a cold water temperature?

BAKER: They were, they were a cold pack which rapidly just became skin temperature and had a sedative effect on

patients. That was an old hydrotherapy form of treating patients, particularly in their excited phase, or if a patient became excited in relation to a delusion or something that they thought was going on, they might prescribe a cold pack. But they also found that continuous tub flow was effective. And that was another one of the things they had, float tubs, that they used.

LEVINE: Were they a normal-sized bathtub?

BAKER: Yeah.

LEVINE: With water flowing constantly.

BAKER: With water flowing through them at a fixed temperature.

LEVINE: Would it be a low temperature?

BAKER: No. It would be lukewarm. Because if you, it's possible to lower the body temperature at an, to an undesirable level if you use too cold a water. So while we called them cold packs, I said they ended up being really at skin temperature.

LEVINE: Now who would, who would, did you have nurses or

psychiatric aides who would be with the given patient while they were having the water pack treatment?

BAKER: Uh, rather than having a water pack treatment?

LEVINE: No, would they be with a particular aide or nurse during, how long a period of time would they, would a patient be in a water pack treatment?

BAKER: You might order a flow tub for an hour and the nurse would be, or the hydrotherapist, that was a special variety of physical therapy. Or the nurse, or the hydrotherapist would be with them. Constantly the patient would be under, like you might have four or five flow tubs with a hydrotherapist and a couple attendants there constantly. I was fortunate because we had, psychiatric nursing had become an accepted branch of nursing by the time I hit the psychiatric field, and we were fortunate in having nurses that were trained to deal with psychiatric patients.

LEVINE: Were there flow tubs at Ellis Island?

BAKER: Yes, there were. But they were there, but we never used them, because it was, it was so much more effective, the shock treatment was so much more

effective in controlling the excited stages of, one of the diagnoses was catatonic excitement. And this could interrupt, it was almost miraculously, you never hear of catatonic excitement any more, but that used to be the way out for many patients. Because, and that's not because of shock treatment, it's because these drugs are effective in controlling the excitement. But we used what we had in those days, but when I first, when I was in my residency up at New York Psychiatric Institute on 168th Street, I think it's still there . . .

LEVINE: Yes, it is.

BAKER: They had hydrotherapy six, eight tubs, hydrotherapy tubs. They were, as I said, some insulin therapy was being given. There was a little reluctance to use shock therapy. Well, I shouldn't say, I should say some of the staff were reluctant to use shock therapy, but it was being widely used in spite of the opinions of some of the staff.

LEVINE: What was the reluctance based on?

BAKER: Most on the punitive effects. They viewed it as a punitive procedure.

LEVINE: Did the patients view it that way?

BAKER: Well, actually, initially before electric shock therapy, we had a drug that was injected that would produce a convulsion, and many of the patients, because the effectiveness of producing a convulsion had been established before we, the shock machine came along. I forget the name of the drug we used, but the patient, when they got this drug, it caused an anxiety reaction, an acute anxiety reaction initially that they remembered, and they would be apprehensive about further treatments. You didn't have that with shock treatment. Or you had it to a lesser degree. Patients would be reluctant to receive electric shock treatment, but it would, it would be on the basis of they're reluctant to doing anything to them.

LEVINE: When they would be, when they had to be tied down or strapped down . . .

BAKER: No, you didn't.

LEVINE: No?

BAKER: That's what you didn't do. Places did do that, but it was found that just by riding with the patients'

motions, restricting them so that they couldn't become, not fully restricting them because you were apt to produce fractures that way, but just riding. What they'd usually have is someone up at the head of the table administering the treatment who would protect the head and neck and two, one people on each arm and leg, one person on each side restricting a patient's movements, but gently. Not a rigid restriction, because that caused fractures. I'm convinced of it. But . . .

LEVINE: Did the patients remember having the electric shock administered?

BAKER: No, they usually don't. They know that something happened to them, but other patients tell them, of course. And we make no bones about telling them that they were on shock treatment. And some of them were even able to appreciate it while they were on treatment. At one stage there, we'd give between fifteen and twenty treatments before we stopped, because we found that giving a fewer number of treatments, and the patient was more apt to relapse. When we, even though we had had a good initial effect.

LEVINE: Would you give them daily or weekly or . . .

BAKER: We found that you couldn't vary, you could either, we found that giving shock daily produced a pronounced amnesic effect, and that it was more apt to be prolonged, the amnesia, doing them daily. We found that the best interval was three times for the first week and then drop off to two a week thereafter for the balance of treatments. But it all depended on the type of case we had. For example, with catatonic excitements we would have to give maybe two a day, three till we controlled the excitement and then back off to the less frequent treatment.

LEVINE: Were you kind of, it was all a little bit of experimental at that point, or I guess it remained that way for each individual? Is that how . . .

BAKER: Yes, it was. It was dealing with a particular patient, and what they were showing, what their main problem was.

LEVINE: Well, how have drugs produced, or what better effect have today's drugs produced that electroshock wasn't able to do?

BAKER: Well, I don't know whether you could even say there are fewer complications. (he laughs) We had gotten electric shock treatment to where there were very, very few complications. But the ease of administering it, you can give a patient a pill or, if they're reluctant, an injection of medication. And that's so much easier, simpler and many of these drugs are equally effective if not more effective with the schizophrenias. It's a moot question as to the effectiveness of these drugs and the anxiety neuroses because, like Valium. Valium can be a very effective in relieving an anxiety attack or effective in an anxiety neurosis. They're different things. But you very rapidly build up a psychological dependency to the Valium that then requires a higher dose of Valium to be effective and you get into an addicting effect. And Valium, if used properly, is a very effective drug, but too many people, there are too many people just handing it out like candy.

LEVINE: Was there a dependency effect with the electroshock?

BAKER: No. (he laughs) No, I never heard of anyone asking for more electric shock. (he laughs)

LEVINE: I mean did, was it necessary to continue giving it when symptoms might recur at some later time?

BAKER: There was such a thing as giving additional shock treatment at a later date if the symptoms recurred, but then you just go for the briefer period and stopped the treatment.

LEVINE: There wasn't a detrimental physical effect?

BAKER: The amnesia bothered the patients a good bit, the fact that they couldn't remember and felt a little confused. Usually that would disappear after a period. The more shock treatments you gave, the longer it took to dissipate and the more the patients would react to it.

LEVINE: Well, wasn't the amnesia helpful in being . . .

BAKER: No. They found it disturbing.

LEVINE: But what about the delusions? Didn't it block them as well?

BAKER: But they still couldn't use their minds for recalling things, and that is disturbing to a person. But, as I say, we're talking about a transient effect. Yeah, we

even had the problem of having hysterical reactions where the patient felt they couldn't remember but, and claimed they couldn't remember when it wasn't so. They thought it wasn't so, and we had ways of proving to ourselves that they really could remember, and we could use reassurance, and we wouldn't get into an argument with them, "Yes, you can, no, you can't." That sort of thing. We'd just reassure them. And as they got, went about their normal activities, why, that would, that was like, we didn't have too many cases of hysterical conversions on the amnesia problem, but it did occur.

LEVINE: Did you ever use lobotomies on Ellis Island?

BAKER: Uh, I was trying to think. We didn't use it. (he pauses) We used it, I don't remember whether we used it on any cases at Ellis Island or not. I don't think so. But it was being widely used then and, the ice pick operation, they used to call it, because it would be like shoving an ice pick in above the eyeball to, and doing this way with it to sever the connections in the frontal lobe. (he gestures) But I think we had a, as I recall a few cases where they didn't respond to anything at Fort Worth that they

went and did a lobotomy. But it was never very popular, and unless we had, most of the cases that didn't respond from Fort Worth we would transfer to a VA Hospital after, sometimes it was six months, sometimes it was three months, depending on how they responded.

LEVINE: I think maybe this is a good place to pause. I want to change the tape.

BAKER: Okay.

END OF SIDE TWO, TAPE ONE

BEGINNING OF SIDE ONE, TAPE TWO

LEVINE: This is Janet Levine, and this is Tape Two of my interview with Dr. James Baker, who was the director of the neuropsychiatric service at Ellis Island from November, 1949 until March, 1951.

BAKER: Yeah.

LEVINE: Okay. We were talking about, so have we covered the kinds of treatments that were done at Ellis Island? The water therapy, talking therapy.

BAKER: I prefer to think of it as psychotherapy, but it's

talking therapy. (they laugh)

LEVINE: I guess as compared with water, electroshock, insulin. Maybe you could talk about the typical kind of problem or problems that you encountered as a psychiatrist on Ellis Island.

BAKER: Well, at that time our patients were mostly merchant seamen and Coast Guardsmen. It was only an occasional immigration case, because at that time the Immigration and Naturalization Service had moved off the island.

LEVINE: And this was both during your residency and also when you were back as director.

BAKER: I think they were rapidly moving uptown when I was a resident there, and they had moved a lot of their facilities up to 58th Street or wherever they are right now, or they may not even be there right now. But they had moved a lot of their stuff ashore. There was still some activity over on the immigration side of the island but, it was called First Island, I believe, but it was minimal. Most of the cases we saw were cases of either acute depressions with suicidal threats or other self-destructive implications, and the schizophrenias. The immigration cases were, an

immigration case wouldn't get to this side of the water if it had been detected at the other end because it wouldn't have been approved for a visa. Most of the cases were, where for some reason or another they uncovered a psychiatric illness en route or they had a nervous breakdown aboard the vessel that they came over on. Or they had a convulsive seizure. A large number of the cases were where tuberculosis wasn't uncovered or diagnosed at the consul or station. Those we didn't have anything to do with. And they were getting quite few. Second Island was the medical wards, and the paper administrative work. And Dr. Ginsburg was, who was in charge of medicine at Ellis Island, he was a civil service guy. He wasn't commissioned. He got to where he had very few patients, two or three.

LEVINE: Did you deal with detainees or deportees?

BAKER: No, we didn't deal with them. We made the diagnosis. We did a, went through a process of, we certified the diagnosis. And if it was mandatorily excludable from the country, there was no appeal.

LEVINE: What was mandatorial, mandatorily excludable in your

field?

BAKER: Ah, history of a psychopathic tendency, either as evidenced by antisocial behavior. If they had a prison record they couldn't get in. Any mental illness, particularly the schizophrenias, the overt psychoses. Like maybe a patient would have an organic psychosis. Chronic brain syndrome, which was, would cover evidence of senility. Alzheimer's, well, it wasn't diagnosed in those days. It was only diagnosed at an autopsy. But the patients who were having early Alzheimer's symptoms wouldn't be admitted, and the convulsive seizures. We didn't have too much of a problem with the, other than convulsive seizures with the neurological disorders. They were self-evident most of the time. And I don't think an adequate history on the other side of Huntington's career or something like that in the family, they wouldn't have an adequate history on that, so maybe some cases slipped through.

LEVINE: Would you get, very often would it be hard to get records of a prison term in Europe?

BAKER: Uh, usually if there was any reason to suspect that

the, at the immigration hearing, if there were any reason to suspect the Immigration Service would get us any records that were available. But on the psychopathic side, sex offenses, maybe somebody would have talked too much aboard ship and they were, and there would be reason to, this guy's not straight and there would be an immigration, a preliminary immigration hearing on that, and they would send them to the hospital for a fuller evaluation.

LEVINE: Did you use psychological tests at all?

BAKER: Oh, yeah, yeah, sure. We used, when I first went there in residency the Rorschach wasn't too much used. The second time I was there we used it quite a bit, and we used the personality inventories and the, I forget all the names of the tests.

LEVINE: MMPI, you probably used.

BAKER: MMPI, Minnesota Multi-phasic Phasing. Yes, we used all those.

LEVINE: Were there psychologists on staff?

BAKER: Yes.

LEVINE: And they were also employed, were they commissioned officers, or were they . . .

BAKER: I, the psychologist that we had there the last time was not a commissioned officer. He came in not every day. Maybe three times a week to do testing, or we could call him in an emergency if we wanted something else done. But yes, we used tests.

LEVINE: For mental retardation? Did you . . .

BAKER: Oh, mental retardation, yes. I forgot that.

LEVINE: Wechler's, probably you used.

BAKER: Yeah. You have to be very careful, because a lot of these, a lot of these immigrants didn't speak enough English, or it was rarely that they did. And many of the Orientals, they'd just dummy up when they get in a stressful position, and they don't answer anything. So you have to be very careful of, they would suspect that the individual was mentally defective, and then you'd get a history that contraindicated that, like maybe they had had an education to a certain level, or some of that, or done this sort of thing and that sort of thing. Which if you could get them talking, and

we'd usually have to work through an interpreter, and that's where we had much of our difficulty. As I mentioned in my letter, this one girl that was with the language department up at . . .

LEVINE: NYU, I think.

BAKER: At New York . . .

LEVINE: Oh, not . . .

BAKER: NYU, uh . . .

LEVINE: City University of New York?

BAKER: Yeah. She was a crackerjack at appreciating what we were driving at. And any time I could use her, I did. (he laughs) And as I mentioned in my letter, I wish I hadn't have been so dependent on my secretary for remembering her name. (he laughs) Because I'd just say, "Get," whatever her first name was, "See if you can get her for this case, ask for her." But the trouble with most of the immigration interpreters, they would talk with a patient and then talk a long string and talk a long string, and then come out with, "He says, 'yes.'" (they laugh)

LEVINE: Not how he said it, or what he said about it.

BAKER: They tried to make sense out of them.

LEVINE: The content.

BAKER: Yeah, of the contents. And that wouldn't be what we were driving at.

LEVINE: Right.

BAKER: But, uh . . .

LEVINE: Did you have many Orientals?

BAKER: We only had a few. I only remember about two being . . .

LEVINE: Well, they would have had to have been seen or in the Coast Guard or something for you probably to get them.

BAKER: I think we had two Orientals that were immigration cases during the time I was there. But I wouldn't swear to that. We had this citizen of the world that I mentioned in my letter that renounced his citizenship. (he laughs) It kind of backfired on him, because when he tried to come back in he had had a convulsion shipboard. And he was promptly sent to

Ellis Island for an evaluation for seizures. And I also mentioned that his father was well-connected, being a society bandleader and, who played at all the big functions in New York at that time. And I had this Doctor Wexler, who was the dean of American neurology. He wrote the textbook that everybody used at that time, and he called me up, the guy had hardly got there when he called me and informed me that he had been elicited as a consultant and was very much surprised to find out that Immigration and Naturalization rules wouldn't allow him to see the patient in any sort of evaluation. But we opened up the hearing to him because he could be at the hearing.

So, and as I indicated in my letter, I don't think, I don't think that this young man will further renounced his citizenship, because he had too hard a time getting back in. And I understand that then they only originally admitted him on a temporary visa for further evaluation, and I heard that it was later made permanent. But, boy, he was a scared young man, because he had seen enough of the other side to want back in the States. But, no. Our relationship at that time with the Immigration Service, we had very few patients of theirs, and as I say, the vast

majority were merchant seamen and Coast Guards.

LEVINE: When you were there as Director of the Neuropsychiatric Service, how many patients might you have at any given time?

BAKER: Oh, (he pauses) about a hundred.

LEVINE: And how about staff?

BAKER: Oh, I had residents-in-training, I had four residents-in-training, and three staff besides myself, psychiatrists. Well, it was a little specialized. The variety of cases that they saw there were, for the residents-in-training, were the same they would see not in a psychiatric practice, but they were the kind that they would see, that, in a hospital.

LEVINE: There wasn't anything specific to seamen or Coast Guardsmen that stood out.

BAKER: No, there wasn't. They had the usual variety of psychiatric illness. We would occasionally have a seaman that was incapacitated with an anxiety neurosis, but that was rare. We'd usually, it would usually be a psychoses or a convulsive seizure sort of problem or that sort of thing. And frequently they

would be sent, they would go to their ship's medical doctor, the in-port medical physician, and he wouldn't, he would get an, he would immediately get an EEG, that's an electro-encephalogram. And not knowing how to use the EEG, he would be quite confused if they had a negative electro-encephalogram. But we knew that you had to have a series of electro-encephalograms before you could establish a diagnosis, unless you were lucky and got a diagnostic reading the first time. But you usually only got that when you had an electrical activity buildup that was pre-seizure.

LEVINE: Were you using EEGs at Ellis?

BAKER: We didn't have, we had to send out to get the EEGs. We didn't have an EEG machine there. We did at Fort Worth, but I don't know how, with the current that they had on Ellis Island, why, I don't know how that worked. (he laughs)

LEVINE: Well, lets talk a little bit about your living quarters there. Could you describe for the tape your living quarters on Ellis Island?

BAKER: Well, it was a two-story, well, I guess it was really

three stories because there was an attic, a large attic topside, but as far as the quarters were concerned there were only two floors that we lived on, the first floor and the second floor. And the medical officer in charge lived right across the hallway from me. So there were two sets of quarters there. There were four bedrooms, one bath, as quarters frequently were at that time, and a very large living room, dining room and kitchen. The living room we could get three full suits of suites of furniture in it. It was about, it must have been twenty by thirty, or even larger. And they were well-furnished. We had a black kitchen stove, electric, that was very workable, but it was a shipboard stove, and it worked on the two-thirty-two wire direct current, as did the lights and everything else. That was the only type of current we had. So I had, you had to improvise on Ellis Island.

We had a refrigerator, but it was a shipboard refrigerator. And the other electrical appliances were non-existent. We made them work, but for example the mixer, you'd have to hook it up in a parallel circuit as electric mixer, so it was, you'd hook a light bulb in parallel circuit, and as the mixer would have more of a load on it, the light bulb would get

brighter, and it would slow down. (they laugh) So it wasn't too much of a workable solution. And the same thing with the sewing machine. I hooked it up in series, or in parallel circuit, but the trouble with approximately the wattage of the machine, but the problem was that it, it would, when it went over a seam it would slow down and the light bulb would get brighter. (they laugh) The radios, small radios, were much easier to work in that, but back in those days television was just about coming out. It was fairly well-established in New York, and we knew we wanted a television set, but couldn't figure out a way of working it, because the rotary converter that you needed to run it on would have cost as much as the television set. And they were a little more expensive in those days, but we finally solved that by taking the rotary converter that I used for giving the shock treatment, the hospital had purchased a rotary converter so that we could give shock treatments because it was A/C current, a hundred and ten to a hundred and fifteen volts, that was the shock machine.

So we had to get a rotary converter for that. I found that the rotary converter would work with the television. So after we finished our daily shock

treatments, I'd take it up to my quarters and run the television off it.

LEVINE: Well, what happened when you gave the electro shock treatments? Did all the lights go dim?

BAKER: No, no. Because we ran it off of a rotary converter.

LEVINE: Oh, I see.

BAKER: So it converted the current to a hundred and ten volt A/C. But at that time they were quite expensive, and fortunately they had bought a heavy duty converter that had more capacity than the shock machine used, or I wouldn't have been able to run the television off of it. But at that time a twelve-and-a-half inch set was a large set. In fact, I think that was the only size they had, the tube. (he laughs) So the trouble with that is that the Immigration electrician didn't have an automatic control on his generator, and it would, as the current would occasionally surge, say about the time they cut off their stoves in the kitchens, it would surge and it would blow out a fuse in my television set. So I, fortunately it was readily accessible on the back of the set. I found a place where I could buy fuses wholesale. And it was

surprising how often Pete, the electrician at Immigration, if he were around, and he would be around if something didn't require his attention elsewhere, how he could compensate for that. Oh, during the time we were there we blew, oh, maybe ten or twelve fuses, but it could have been an everyday or more frequent occurrence than that. So he was there most of the time to compensate, to make a manual compensation. But I really had to be a sort of an electrician.

LEVINE: Yes.

BAKER: To live on the island.

LEVINE: What was it like living there, on Ellis Island?

BAKER: Well, we had a front-row seat to the Statue of Liberty.

END OF SIDE ONE, TAPE TWO

BEGINNING OF SIDE TWO, TAPE TWO

BAKER: . . . across the Harbor, it looked right close. It was, the Statue of Liberty is closer to the New Jersey side than it is to the New York side, so it was right in our backyard. We had a front seat for all the maiden voyages of the steamers. You know, they'd give

them a harbor welcome as they come in on their maiden voyage. It was a very pleasant location, but with some drawbacks, mainly the damn ferry. (he laughs)

The Ellis Island Ferry that only ran at fixed times and quit completely with the 10:45 trip from the mainland. I remember running with our tongues hanging out to catch that ferry many evenings, and particularly if you went to a New York show often you didn't get to see the last curtain because you had to leave to make the ferry, and there was no, I really thought that I had made it, because one time we almost missed the ferry and they put back in to pick us up. They never did that. So we felt that we had arrived.

(they laugh) So we didn't go to many shows. At that time Mrs. Baker had a young baby and our son was just in kindergarten. I think he was about five at the time. But that was a complication. The only, we wanted to keep him in kindergarten. They had a kindergarten on Governor's Island that he could go to, but certainly Mrs. Baker couldn't supervise his getting there, and I couldn't. So we enlisted this patient of mine, ours, the paranoid schizophrenic, the burned-out one, to take him over to the school on Governor's Island and bring him back, escort him back.

Fortunately, I had had a little more time to evaluate this Tom person and there really wasn't any need for his being on the island in the first place, because he had what we mean when we talk about a burned-out schizophrenic, particularly the paranoid, is that they no longer react to their delusions except in an acceptable fashion, a more acceptable fashion. And they're no threat to themselves or others, it's just they still have their delusional system. It's there, but they don't react to it. And I realized that he was that type of a case. There was little alternative. He had kind of attached himself to us anyway. As I said in my letter, he was one of the first people we met getting off the boat. I thought he was an employee. (he laughs)

LEVINE: How was he in relation to your son Bill?

BAKER: Except that he would tell Bill to, "Don't get around those people." Some of the males. He was very friendly with the nurses and usually Tom would take Bill, the nurses, some of them departed on the ferry that was leaving when he went over to school, and a lot of them were on the ferry as he came back from school. So he would talk with the nurses and got

along quite fine with them, but these male attendants, and a couple of male nurses, as I said, I wasn't sure which side they batted from to begin with. So he wouldn't have anything to do with them, told my son to stay away from them. Didn't give him any reasons, just told him to stay away from. But outside of that, he was well-supervised on the trip. The Ellis Island, the, I don't know. Do they run a ferry to Ellis Island now?

LEVINE: The Circle Line takes tourists to Ellis Island and the Statue of Liberty on a regular basis from New Jersey and from New York.

BAKER: They don't use the old Ellis Island ferry, I bet.

LEVINE: They're very similar, but they're not the same boat.

BAKER: Does it still use the same dock?

LEVINE: Right in front of the main entrance to the Great Hall. That's where they dock, where that canopy is, on Island One.

BAKER: Oh, yes.

LEVINE: So not . . .

BAKER: I'm taking off from the, from the, uh, Manhattan side.

LEVINE: Yeah. Oh, where do they dock there?

BAKER: Yeah.

LEVINE: Battery Park, just a little bit south of Fort Clinton, what was Fort Clinton, formerly Castle Garden? You know, it's a round building.

BAKER: Well, maybe that's, Fort Clinton was further up the line.

LEVINE: Well, this is . . .

BAKER: The Ellis Island ferry used to take off right from down at the Battery. It was just a short distance up from the Governor's Island ferry.

LEVINE: Well, do you know where the Coast Guard building is at the tip? Uh, kind of, let's see. To the west of the Staten Island ferry departure place.

BAKER: Uh, let's see. Where did the Staten Island Ferry take off? It was below, it was to the east of the Governor's Island ferry. And then there was a Coast Guard pier on up the line about, oh, a quarter of a mile.

LEVINE: Oh, uh-huh.

BAKER: And maybe that's where they built the Coast Guard building, because they owned the pier.

LEVINE: So where did the ferry go from when you took it, to Manhattan?

BAKER: It went right down there to the Battery, to the Ellis, to the, probably where they entered between, just to the west of the First Island. There was, there was only one place that you could dock the ferry.

LEVINE: Between the First Island and the Second, in front of the Administration Building and those medical hospital buildings. Is that where?

BAKER: They were to the left. They were on second and third island. The immigration side was to the right on first island, and I guess you did call that the Administration Building. We used it for medical administration at the time we were there, but because immigration wasn't on the, except for Pete the electrician, and they may have had around a couple of maintenance worker, that's all the immigration stay for on the island. But the, there weren't any stores

down there where you could buy groceries.

LEVINE: Were there people coming in to work from the New Jersey side at all?

BAKER: Oh, no. They never come in from the New Jersey side. That was just a bunch of docks and ships and very commercial. There wasn't, uh, there was no traffic from the New Jersey side. It was all from the New York side, and it was all, an occasional Coast Guard boat would put into the slip there, the ferry slip. But that would just be if they had emergency business on the island, like maybe bringing a patient there or something like that. There is no traffic. I was the first, I drove the first car that ever was on the Ellis Island ferry. And I come over to load, when I was leaving I brought my car over, drove over, around the hospital to the, to my quarters, and loaded my family up and went back on the next ferry.

LEVINE: You also did a first by landing a helicopter.

BAKER: Yes. I landed a helicopter up there, and let me get this straight. I forget what the dates were, but we landed between Second and Third Island, between the two medical wings quite close to where I later

occupied quarters. We had no flight plan that covered landing there, so we didn't tarry too long. I landed mainly because it was there and I wanted to do it.

(they laugh)

LEVINE: This was when you were at Floyd Bennett Field.

BAKER: Yes. And it was about April some time of, '46 was it?
No, no, it wouldn't be.

LEVINE: '42.

BAKER: April of '42, yes. Yeah. April of '42. It was some time about then, the people come out, streamed out to see what was going on. There were patients on the hospital then, and I knew a couple of them. I didn't know that I knew them, but I recognized them. And, as I said, we didn't tarry long because I wasn't sure how legitimate it was. But the next thing we went from there over to Staten Island, and I landed on the end of a Coats Guard pier over there, so I don't know how legitimate that was either. (they laugh) But they kind of got to where they didn't know what rules to apply to the helicopters, so most anything went. I flew up one time. I'd make the Harbor patrol occasionally just to be flying the helicopter and

looking around New York. And I'd fly the Harbor patrol. Sometimes I'd have a mec with me, and sometimes I'd fly it alone. But one time I was going up the Hudson there and the George Washington, we were very low. The George Washington Bridge unloomed ahead of me, and I started to climb up. I thought, "What the hell? I can go through this easier than climbing."

LEVINE: Go under?

BAKER: So I went under the bridge.

LEVINE: Oh, my goodness! (she laughs)

BAKER: And I just did it, to go under the bridge, and turned around. My God, it was reported in the papers and someone saw us. I was very careful, because I didn't, I slowed to almost I was hovering to go under the bridge because I wanted to see that nothing was hanging down. And as I got under it, went under it and turned, the only thing I wanted to do then was get out of there. But we made the Harbor patrol, mainly to see if there were any oil slicks, if there were any evidence that vessels were cleaning their holds and if there was any unusual debris on the water. I never

caught a vessel doing that, but . . . (he laughs)

LEVINE: You had a good time.

BAKER: We'd get down the Jersey side and around there, and it was a very interesting experience.

LEVINE: When you look back on it now . . .

BAKER: I look back on it fondly. I enjoyed my, I was ready to leave, but I enjoyed my tour of duty there.

LEVINE: And how about being a psychiatrist and having the, your son in his formative years there, what do you think the effect on your son was to have been there?

BAKER: I don't think, that's the son that's now up, Bill, the one that he interviewed, he's with IBM. I don't think it had any effect on him, except he remembers it fondly, too. I don't think his association with a paranoid schiz, he saw Tom as a friend, as a friend who took him to school each day. And unfortunately, he had to walk about three-quarters of a mile to kindergarten because the kindergarten bus had already picked up the people, so he couldn't catch it at the ferry slip, but he did ride the bus back in the evening. And Tom would just have to meet him at the

Governor's Island ferry slip where the ferry docked. So, and as I said, he just had a short distance to, maybe about a couple of hundred yards.

LEVINE: I see. Well, you wrote so beautifully about Tom and the character that he was, and we'll have this letter in our file as well as in the tape, but what do you think happened to Tom?

BAKER: As I . . .

LEVINE: What would be your guess, I guess, because you really don't know what became of him.

BAKER: Ah, he, I don't know. He had his seaman papers. He may have shipped out. And gosh knows, he had plenty of sea experience, so he probably wouldn't have had any trouble, particularly on a tanker. But he had shipped, he had shipped out on other type vessels.
(a telephone rings) (break in tape)

LEVINE: Okay. We're resuming now after a telephone call. Ah, let's see. We were saying, you were saying that Tom might have shipped out on a tanker. But I was curious. He really didn't need to be there, you thought. Why do you think, did he choose to be there?

Is that why he was there?

BAKER: Well, I guess he was a little more disturbed when he first came in. He was, he wouldn't talk about these delusions that he had to just anybody. But he may have gotten a circumstance where he was under pressure and he thought that people were trying to make him into a homosexual. You know, that was his big thing. Or I'm more inclined to think that he talked to somebody about his feelings when he shouldn't have, and that precipitated. He really didn't need to be there. He was perfectly content to stay there with us because I think he kind of saw us as family and it was his God chosen duty to look after us. (he laughs) Uh, he wasn't a religious man at all. I don't think he was, because I never heard him talk about religion. But he had this fixed delusion, and he went, he was supposed to go over to the St. George Hotel. I called to see if he had checked in, he had never checked in. I called back the next day before we left to see. I don't know what happened to him, and that's the last I ever heard of Tom. But no, I'd have liked to have kept in touch with him. But I'm not surprised. I wasn't sure that he was going to do what he had told

me he was going to do, check into the St. George. I think he really intended that, but I don't know what happened in the meantime. But he never got to the St. George under the same name. He could have been registered there under a different name. The St. George was very popular for seamen to go to in New York. So he may have registered under a different name.

LEVINE: You also mentioned in your letter about the Irish nurses.

BAKER: Oh. They weren't Irish nurses. They were mainly kitchen help. Now, I don't know whether, they may have been Immigration employees. I think they were. They had worked on the island for years and, as I said in my letter, Ellis Island became home to them. Because they may have moved ashore to a different location, but Ellis Island was the one thing that kept constant. And a lot of them had considerable misgivings when they heard the island was going to close. One of them, this Nora, even wanted to work for us until she found out that I was being transferred to New Orleans (he laughs) and wasn't staying in New York.

LEVINE: Was this group of women older?

BAKER: Older, yes. They were all older. As I said, they probably come over in 1900 influx of Irish immigrants that came into this country and apparently never got beyond, turned out to be such good workers that the Immigration and Naturalization Service hired them.

LEVINE: Do you know where they lived?

BAKER: No. I never knew where they lived. Many of them were married. They still continued working on the island. They were mostly, they worked in the kitchen. They did maintenance-type work. Nora and Lillian were, I don't know, I guess they were maids. Lillian was a colored girl. She was not, she was hired, she lived in New York City and she was hired from there, but Nora and a lot of the other girls were in that Irish immigration influx to the United States that occurred around, you probably know more about it than I do, but it was around the 1900's.

LEVINE: Well, anywhere, yeah, from 1850's on to the turn of the century.

BAKER: So many of them were eligible for retirement, had

been, for civil service retirement. And, but it was unusual in the way they, the affection that they attached with us, to us, even though we had just been there on the island a short time. But this Lillian wrote my wife for years. She would send her a Christmas card and put a note on it, and I imagine she's died.

LEVINE: Was there much of a community sense of the people who were living on the island? About how many families would you say were there, or how many people?

BAKER: There were only, there were only four families living on the island. The medical officer in charge, myself, the administrative officer who was married but with no children had an apartment. And one of the residents who had two kids and was having trouble finding a place, they made an apartment for him, or had this place that he could utilize. Len Ganser, he's since come into psychiatry and did very well. He's out from the Wisconsin area, but . . .

LEVINE: How many staff members would you say came out on a daily basis?

BAKER: Oh, gee. In other words, rode the ferry? Uh, three?

About six of the medical staff, but doctors, six doctors. But nurses and all of them, there were no quarters for nurses on the island. All of them rode in the ferry.

LEVINE: And so there were two shifts also, right?

BAKER: Three shifts, and some of them were staggered shifts. But three full-time, three eight-hour shifts.

LEVINE: Were there a dozen nurses on a shift, or just some idea of how many?

BAKER: Oh, there were two nurses to a ward. We had five wards. On the acutely disturbed we had three. I imagine there were about, I would estimate about twelve, fourteen nurses rode the day shift. We'd usually only have . . . (tape ends)