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Thesis

SANATORIUM CARE FOR THE TUBERCULAR POOR
IN HARTFORD, 1900 - 1910

Submitted by

Sandra L. Wheeler

(B.S., Columbia University, 1963
M.A., University of Connecticut, 1980)

In Partial Fulfillment of Requirements for
the Degree of Master of Arts

1993

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PREFACE

People have always suffered from disease. It is, however, as much a social as a biological construct: What defines the state of being ill, and what is considered an appropriate response to it, differ both cross culturally and over time. As Charles Rosenberg says, perceptions of disease are both "context-specific" and "context-determining."¹ To the social historian, investigating the expressions and effects of disease can be a fruitful way to study the contexts in which they occur -- social institutions, gender roles, religious beliefs, power relationships, political forces, class and racial divisions.

If the study of illness can be a boon to the historian, however, it can also be a bane. Some responses are highly visible (hospitals, nurse and physician roles, health insurance) and not too difficult to interpret. Others, however, are emotionally charged, not visible at all and present serious research problems. Did a diarist not mention the illness from which a loved one died because it was unknown, or because it was too painful (or shameful) to think about? How can we know the "codes" by which socially unacceptable diseases were discussed, or recover the knowing look or lifted eyebrow by which people conveyed information about them? How can we tease out prescriptive behaviors for patients, families,

¹Charles E. Rosenberg, "Introduction," in Framing Disease: Studies in Cultural History, eds. Rosenberg and Janet Golden (New Brunswick NJ: Rutgers University Press, 1992), p. xx.

care-givers when they were often deeply embedded in the cultures in which they occurred? How can we convince guardians of medical records that historical research is a respectable undertaking in which it is possible to honor tenets of medical confidentiality?

For the social historian of the early twentieth century, studying tuberculosis offers all the rewards and frustrations alluded to above. It was in some ways a new disease because its communicability was demonstrated only in 1882, but it was also an old disease, and people knew its symptoms and how it progressed. Accessible as much information is, it is almost impossible now to recover what the experience of being sick and dying of tuberculosis was like. There is an amazing paucity of representation of the disease in any artistic medium; materials in letters, diaries, memoirs and autobiographies is scant in the extreme. The silence surrounding the disease suggests that people were both ashamed and terrified. Such feelings persist still. On a visit to a town in upstate New York near both Trudeau's famous sanatorium and a state tuberculosis facility, both closed for nearly forty years, I asked at the local historical society if any section of the town still contained a concentration of houses with sleeping porches (an indication that they had housed tuberculosis patients or ex-patients). The sixty-something lady at the desk informed me in outraged tones "people like that" had NEVER lived in HER town.

Rosenberg's comment that perceptions of disease are context-shaping was in my mind constantly as I wrote this paper. It has become apparent in the last five years that people with AIDS have

developed antibiotic-resistant strains of tuberculosis. If antibiotic therapy has indeed lost much of its efficacy, tuberculosis today could be as communicable and dangerous as it was one hundred years ago.² Like many consumptives at the turn of the century, today's tuberculosis patients are defined by middle class society as "other." In 1900 they were often the immigrant poor; today they are the HIV-positive. If we are to make thoughtful decisions about how to ensure that these new consumptives obtain effective, humane treatment, we should be informed about the results of reactions of physicians, policy makers and citizens at the turn of the century.

A project such as this inevitably owes much to many. My interest in Hartford and appreciation for what a fascinating city it is was first stimulated by Susan Pennybacker; she and the members of the Hartford Studies Group have been continuing sources of encouragement. Barbara Sicherman's contribution antedates her helpful comments as reader; my research on tuberculosis began as an independent study paper I did for her which appears here in altered form as Chapter I. Her knowledge of related work in the social history of medicine and public health is truly encyclopedic and made identifying secondary sources much more complete than it would have been without her. Eugene Leach was a most tolerant

²The recent periodical literature covering this development is extensive. The best summary of the social and medical ramifications of the re-emergence of TB appeared in a series of articles by reporters Michael Specter, Elisabeth Rosenthal and Lawrence Altman in The New York Times (October 11 - 15, 1992). See also Ken Chowder, "How TB Survived Its Own Death to Confront Us Again," Smithsonian 23 (November 1992): 180 - 194.

thesis advisor, since I had no idea when I began where the research would lead. The final product has benefitted greatly from his careful, thoughtful reading, comments and questions. Finally, the research would not have been possible at all without the assistance of Steve Lytle, archivist at Hartford Hospital. I was fortunate that the principal sources of information I would need were in a repository so well organized and so efficiently run. Steve also answered questions, located photographs, and even managed to listen patiently and with every appearance of interest when I insisted upon telling him about new bits of information I discovered in the old board minutes he found for me. To all these people, as well as to friends and members of my family who now know more about tuberculosis than they ever wanted to, I am grateful. Responsibility for facts and interpretations offered here, of course, is mine alone.

INTRODUCTION

One of the cliches of historical discourse is that Progressive Era reform in the United States brought with it bureaucratic structures through which professional elites sought to contain and control burgeoning, often unruly, urban populations. As this study will show, however, concepts as abstract as "social control" are not adequate to explain real events. An investigation of forces which shaped the institutional treatment of the tubercular poor in Hartford, Connecticut in the first decade of the twentieth century must illuminate why, after promoting and funding a voluntary hospital's small sanatorium, city authorities, physicians and a representative of working class interests shifted their support to a state operated network of sanatoria for tubercular patients. Although fear of the consumptive poor and hence a need to control them was one of the impulses which made the American medical community support sanatoria, such concerns were only background to what happened in Hartford. At least in that city, the economics and politics of both the city and its medical resources were important determinants of policy, and ideas about appropriate solutions to the tuberculosis problem changed quite rapidly. The "social control" rubric, helpful as it is in describing the effects of progressive reform, must be evoked within the context of locally specific circumstances.

BACKGROUND: SANATORIA AND THE PROGRESSIVE ERA

Thomas Mann's The Magic Mountain, set in the years just before World War I, is the story of a young man's seven year stay in a tuberculosis¹ sanatorium² in Germany. The novel remains the classic description of those hotel/hospitals in which patients spent hours lying in the open air, ate large meals, and waited for their disease to cure itself. When we think of sanatoria today, we imagine them as Mann's plush European institution, a separate world in which privileged people spent years of romantic soul-searching while healing.

The reality, at least for working class and poor consumptives in the United States, was rather different. For those without means, the burden of tending a consumptive relative was often insupportable, and such patients ended up in almshouses, city hospitals or public sanatoria. Such patients usually delayed seeking help and so were admitted late in the course of their disease, often unwillingly; their stay was usually measured in

¹"Tuberculosis" as used in this paper should be understood as "pulmonary tuberculosis" unless otherwise noted. The disease most often attacked lungs; though manifestations in other body systems were possible, the pulmonary form of the disease was the most infectious and hence the one physicians and public health officials focused upon. "Consumption" and "phthisis" were other terms synonymous with pulmonary tuberculosis.

²'Sanatorium' is the spelling used by all primary sources reviewed for this paper. Adolphus Knopf, a prominent New York physician and educator active in the prevention of tuberculosis movement, explained: "It is called sanatorium from the Latin word sanare, to heal, and is a healing institution. It is not a sanitarium which, derived from the word sanitas, health, rather means a health resort...." S. Adolphus Knopf, "The Ideal Sanatorium, The Ideal Physician, The Ideal Nurse, and The Ideal Patient," New York Medical Journal 10 (October 11, 1919): 641.

weeks to months rather than in years, and they were seldom cured. It is they with which this paper is concerned.

The American sanatorium movement began in 1885, when Edward Trudeau, a consumptive physician who had cured himself by living a simple outdoor life New York's Adirondack mountains, opened his Adirondack Cottage Sanatorium in Saranac Lake, New York. It became the most famous American institution of its kind and retained its cachet as well as its generous funding by private donors until it closed in 1954.³ Trudeau's sanatorium opened three years after Koch presented his discovery of the tuberculosis bacillus to the scientific community. These two events, Trudeau's successful sanatorium treatment and the identification of tuberculosis as a communicable disease, initiated more than fifty years of efforts to cure people with contagious tuberculosis while isolating them in sanatoria. The mainstays of treatment were rest, food and fresh air. Although the 1930s saw the advent of surgical procedures to arrest the disease by collapsing the diseased lung, real cure was not achieved until the antibiotics developed during World War II

³Robert Taylor, Saranac; America's Magic Mountain (Boston: Houghton Mifflin Co., 1986), p. 74. Although Trudeau seems not to have based his institution upon any specific models, he must have known about sanatoria in Europe, which had evolved from "spas" and "baths" and served an affluent clientele. Active since mid-century, they remained important influences upon American medical thought about tuberculosis treatment at least until World War I. See F.B. Smith, The Retreat of Tuberculosis (London: Croom Helm, 1988), pp. 97-100 for a discussion of Continental sanatoria and the physicians who ran them.

became available.⁴ Beginning in the 1950s, sanatoria closed or were converted to other uses; today only four are left.⁵

Sanatoria were actually hybrids, a combination of two older forms of institutional care for two quite different medical problems. Like pest houses, which had existed for hundreds of years to isolate people with communicable diseases, sanatoria segregated consumptives in facilities outside the cities, thereby removing the sources of infection and protecting their families and fellow citizens. Like mental institutions, which had since the 1840s advocated the importance of a therapeutic environment, sanatoria were places apart, usually in a rural setting, which would heal merely by healthful locations and orderly living arrangements. There was, then, nothing really revolutionary about sanatoria, and they were quickly accepted as at least part of the answer to the terrifying mystery of tuberculosis. Their numbers grew quickly in the first twenty years of the new century; in Connecticut, for example, there were none in 1900 and seven in 1921.⁶

⁴Although the incidence of the disease had been declining since mid-nineteenth century without any effective medical treatment. This point will be discussed more fully in chapter I.

⁵One in each of the following states: Florida, California, Texas and Hawaii. Deborah S. Pinkney, "Florida Panel: Keep TB Hospital Open -- But at Half Capacity," American Medical News 35 (March 2, 1992).

⁶Two of these were private, Wildwood in Hartford and Gaylord in Wallingford. The remainder were public, provided by the state: Cedarcrest (Hartford), Undercliff (Meriden), Uncas-on-Thames (Norwich), Laurel Heights (Shelton), The Seaside (Niantic). State institutions are listed in Connecticut Register and Manual (Hartford: State of Connecticut, 1920), p. 314.

It is important to remember that sanatoria appeared at the same time that traditional modes of medical care were beginning to give way to highly technological institution-based treatment. The advent of effective anesthesia and asepsis and improvement in surgical techniques persuaded more and more middle class patients to agree to be treated in general hospitals rather than their own homes. This development was welcomed eagerly by physicians, as it made their practices more efficient when they could visit many patients at the same time in the hospital instead of going from house to house.⁷ As this paper will show, sanatoria relieved general hospitals of unwelcome chronically ill consumptives and thus made them more attractive to middle class, paying patients.

The first fifteen years of the twentieth century is generally known as the "progressive era." It was a time of intensive immigration and industrialization, of transition from social forms and institutions appropriate to small town face-to-face life to those required by urban mass society. Problems that had been manageable by informal means when they involved a few individuals required new solutions when hundreds or thousands of people were affected. The reforms of the period were carried out by experts

⁷For the emergence of modern hospitals and medical practice, see Charles E. Rosenberg, The Care of Strangers (New York: Basic Books, 1987), especially chapters 7 - 12; Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), especially Book One, chapters 3 - 5; Morris J. Vogel, "Machine Politics and Medical Care: The City Hospital at the Turn of the Century," in The Therapeutic Revolution: Essays in the Social History of American Medicine, eds. Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979), pp. 159 - 175.

who had received formal training in the specific issues involved. These new professionals relied upon bureaucratic measures to implement and manage change so that it was replicable and uniform from place to place; they strove for efficiency so that the improvements could be accomplished quickly and applied widely. They thought government was the only source of manpower and funds large enough to carry out the programs they developed. Governing bodies, responding to their lobbying, began to assume responsibilities for social programs and to legislate upon matters previously unregulated.⁸

All these transformations in the way social services were to be provided were reflected in the acceptance of sanatoria as logical and necessary places in which to treat consumptives. Care was routinized and carried out by physicians and attendants who specialized in the disease. Financial support for the operation of these new institutions, especially when they served people not able to pay for themselves, was more problematic, but generally was assumed by a variety of governmental sources.

THEORETICAL ISSUES

It is surprising that few social historians have studied sanatoria⁹ because such research might provide insight into the

⁸I have in mind a broad range of government (at all levels) interest in previously unregulated areas: child labor laws, school inspections, health department rules etc.

⁹I am aware of only two, Bates and Bryder. Bates' work concerns Dr. Lawrence Flick's career as a tuberculosis specialist in Philadelphia, where he founded a sanatorium, and contains richly detailed descriptions of what it was like to be a worker or a patient there. Bryder is British, and although her book contains

forces which shaped the institutional response to social problems so typical of the progressive period. Hartford is an ideal site for such an investigation. At the turn of the century it was a modest but rapidly growing community with a history of philanthropic responsiveness to civic problems. Although lacking the resources of large mercantile centers such as Boston or New York, as the state capital it attracted sophisticated business, legal and public policy professionals, experienced medical practitioners, innovative manufacturers and learned educators. The population also included large numbers of new immigrants, skilled artisans, and white collar workers. Both people with problems and people with solutions were abundantly present.

By examining Hartford and the changing place its sanatorium, Wildwood, occupied in civic consciousness between 1900 (Wildwood opened in 1902) and 1910 (when the first state sanatorium opened), this study documents changing ideas about what kind of institution physicians, politicians and philanthropists thought was appropriate for the treatment of tubercular patients who were unable to finance their own care. Questions I have kept in mind include the following: What were the alternatives to building an entire new

excellent analyses of sanatorium life and the social effects of the diagnosis upon patients and their families, its applicability to the American scene will not be clear until much more work is done here. Barbara Bates, Bargaining for Life: A Social History of Tuberculosis, 1876 - 1938 (Philadelphia: University of Pennsylvania Press, 1992) and "Quid pro Quo in Chronic Illness: Tuberculosis in Pennsylvania, 1876 - 1926" in Framing Disease: Studies in Cultural History, eds. Charles E. Rosenberg and Janet Golden (New Brunswick NJ: Rutgers University Press, 1992), pp. 229-47. Linda Bryder, Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain (Oxford: Clarendon Press, 1988).

medical facility on the outskirts of town? What were the political or economic factors that affected that decision? Once the sanatorium was functioning, why was there a change in the attitude of those who had favored its construction?

At a more theoretical level, this paper uses the Hartford instance to illustrate and test propositions made by historians which hold that social control was central to the progressive impulse.¹⁰ The concept of a special institution, the sanatorium, to educate and treat patients considered to be dangerous to public welfare is certainly quintessential progressive thought. In Hartford, a sanatorium was built because existing hospitals did not wish to accommodate tubercular patients. When the small facility attached to Hartford Hospital proved insufficient to relieve it of those unwanted patients, its administrators gladly transferred responsibility for them to the state.

Although individual consumptives whose families were unable to care for them had little choice but to accept whatever help was available, could those representing the interests of people

¹⁰The classic statement of the social control thesis is found in Authur S. Link and Richard L. McCormick, Progressivism (Illinois: Harlan Davidson Inc., 1983), pp. 67-104, and Robert H. Wiebe, The Search for Order (New York: Hill and Wang, 1967). Helpful summary articles include: Blaine A. Brownell, "Interpretations of Twentieth-Century Urban Progressive Reform" in Reform and Reformers in the Progressive Era, eds David R. Colburn and George E. Pozzetta (Westport CT: Greenwood Press, 1983), pp. 3-23; Richard Crockatt, "The Progressive Era and its Discontents", Journal of American Studies 17 (December 1983): 437-42; Wayne K. Hobson, "Professionals, Progressives and Bureaucratization: A Reassessment", The Historian 39 (August 1977): 639-58; David M. Kennedy, "Overview: The Progressive Era", The Historian 37 (May 1975): 453-68.

affected by measures intended for their betterment (working class and impoverished consumptives and their families) negotiate and alter the shape those measures took?¹¹ One of the tuberculosis commissioners appointed by the governor of Connecticut in 1907 came from a working class family. He began by supporting the local sanatorium and ended by overseeing the implementation of the state system, probably because he thought it a more certain source of care for those in need. Like Hartford Hospital administrators, he saw the state system as the most palatable alternative, and accepted it as a given that tuberculous patients required institutionalization.

The Hartford case, then, does not question the premise that progressive reformers attempted to regulate and restrict the actions of populations they defined as "dangerous," immigrants and the urban poor, especially if they were also consumptive. Hartford's physicians and policy makers resembled "reforming professionals" and "coercive progressives," who were sure that a better society would result if only others would comply with what they identified as correct behavior and wished to "impose their own ways of living upon other racial and ethnic groups".¹² At the same time, however, events in Hartford also demonstrate that what appears to have been a single decision, to institute a system of

¹¹This question is suggested by John D. Buenker's investigation of negotiations and coalition building between progressive politicians and their working class constituents. See Buenker, Urban Liberalism and Progressive Reform (New York: Scribner, 1973).

¹²Link and McCormick, pp. 85, 95.

state sanatoria, was in fact the outcome of a series of decisions made within the constraints of a local historical context but at the same time responsive to changing political, economic and medical reality. Progressive reform was a dynamic process of experiment, not the result of static bureaucratic fiat.

ORGANIZATION OF PAPER

Chapter I summarizes the literature of American tuberculosis professionals (physicians, nurses, social workers) between 1900 and the first world war. It suggests that controlling "dangerous" and "vicious" consumptives was very much part of the agenda of the medical community. In this sanatoria were little different from other institutions in the progressive era. Mental asylums and prisons also were places in which coercion could replace treatment; in them as in sanatoria there was a significant amount of institutionalized repression, an "unholy alliance between reformist conscience and administrative convenience."¹³ Despite benevolent motives and ideology, medicalization of the behavior of society's misfits did not always (or even usually) make their lives comfortable. To the extent that poor consumptives were identified as deviants who irresponsibly endangered others, they were subjected to treatment which, although seldom deliberately inhumane, frequently lacked sensitivity.¹⁴

¹³Andrew Scull, Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective. (Berkeley: University of California Press, 1989), p. 256.

¹⁴Discussions of forces shaping mental and penal institutions and of medicine as an instrument of social control can be found in: John C. Burnham, "Medical Specialists and Movements Toward Social

Chapter II surveys the Hartford of 1900 to 1910 and identifies sources of assistance and care available to those who could not afford private medical treatment. Although the city had long contained a number of institutions for the care of various categories of unfortunates, it lacked a municipal hospital. As the remainder of the paper demonstrates, the lack of a facility already charged with the care of people such as the consumptive poor forced philanthropic and municipal authorities to grapple directly with the problem they presented.

Richard Wiebe's comment that "the heart of progressivism was the ambition of the new middle class to fulfill its destiny through bureaucratic means"¹⁵ finds validation in the phenomenon of the sanatoria. How could an illness be more bureaucratized than by dedicating a whole new system of quasi-hospitals to it? Chapter III focusses upon Hartford Hospital and its sanatorium. It reveals that, after attempting to treat tubercular patients at a hospital-run sanatorium, Hartford professionals concerned with tuberculosis did not object to the construction of a system of state sanatoria. Transferring destitute consumptives to state hospitals freed

Control in the Progressive Era: Three Examples," in Building the Organizational Society, ed. Jerry Israel (New York: The Free Press, 1972), pp. 19-30; Gerald N. Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in The Therapeutic Revolution: Essays in the Social History of American Medicine, eds. Morris J. Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979), pp. 136-57; David J. Rothman, Conscience and Convenience: The Asylum and its Alternatives in Progressive America (USA: Harper Collins, 1980); Scull, Social Order/Mental Disorder.

¹⁵Wiebe, p. 166.

Hartford Hospital beds for middle-class, paying patients. In this, the hospital was in main stream of early twentieth century hospital development and became (and has remained) a technologically sophisticated acute care institution.

The extent to which even powerless and destitute patients controlled their own destinies in the face of concerted efforts to institutionalize them is most evident in their unwillingness to accept hospitalization at all. (Illustrated in the medical literature reviewed in Chapter I.¹⁶) Such individual resistance was insufficient to change policy, however, and the ability of such people to combine to exert political power was limited. Nevertheless, some evidence for what Buenker calls "coalition building" in Hartford does exist. Chapter IV relates what is known of John Gunshanan, a politically well connected son of a working class Irish immigrant who at first promoted Hartford Hospital's Wildwood Sanatorium and then advocated the construction of state sanatoria. Since none of his personal papers have survived, it is not certain why he and his constituency came to favor state rather than local facilities. It may be that state institutionalization was a way to avoid tuberculosis wards in a city hospital located in the stigmatized almshouse, admission to which was resisted by the working poor and destitute alike. In addition, the future of sanatoria run by general hospitals was not hopeful; Hartford Hospital's commitment to Wildwood was less than enthusiastic.

¹⁶It is also a major theme addressed by Bates in both her short paper and monograph.

Information about what maneuvers were necessary or what coalitions were built to ensure legislative approval of and appropriations for state sanatoria has not survived. That five hospitals were built in ten years is proof of Gunshanan's success and supports Buerker's suggestion that the acted-upon could sometimes affect their own destinies.

This paper concentrates upon sanatorium care for the working poor and the destitute because in the eyes of progressive reformers and medical professionals they threatened the health of the larger community in ways that middle class consumptives did not, and because the institutions to which they were sent, unlike Trudeau's establishment at Saranac or Mann's in Magic Mountain, were not luxurious retreats into either health or an aesthetic death. We have forgotten what happened to the needy consumptives of urban America, and have forgotten what the places in which they were confined were like. Unfortunately, almost all traces of their voices have been lost in Hartford. Their families did not deposit their letters or diaries, if any existed, at the historical society. They did not publish memoirs in their successful and comfortable old age. No newspaper or magazine reporters visited them for material for "human interest" stories. The Medical Records Department of Hartford Hospital denies ever having received their medical records. All that is left of such people are a few trails among bureaucratic records; the story of one of those families, the Barbellas, is recounted as part of Chapter III. The Barbellas, whose hopeful beginnings in the new land ended in

tuberculosis and death in public institutions, will have to stand for a myriad of others. This paper is dedicated to the memory of all of them.

CHAPTER I

TUBERCULOSIS AND SANATORIA, 1900 - 1915

Tuberculosis at the turn of the century was in many ways a new entity. Koch's 1882 discovery of the causative bacillus redefined it as infectious rather than inherited, as had been thought previously. By 1900, the germ theory was widely accepted,¹ but it took some time for its implications for the treatment of tuberculosis to affect medical practice and social policy. The emerging discipline of public health would undertake the prevention and control of tuberculosis as one of its central missions. Public health authorities were not concerned about those already ill except insofar as they could infect others. Sanatoria fit into their plan as places in which to educate patients about how to lead healthful lives, and, more importantly, as places in which to isolate the contagious.

The early years of this century were also a time of great change in medicine and medical practice. The general hospital became the workshop of the physician and the locus of training for medical professionals. Physicians began to base their practices in hospitals, efficient and convenient places in which to treat patients; as a result, hospitals began to accommodate middle and upper class patients as well as (though in different wings from)

¹Nancy Tomes, "The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and the Germ Theory, 1870 - 1900," Bulletin of the History of Medicine 64 (Winter 1990): 509-39.

control in hospitals and operating rooms made them safer, general anesthesia technology became widespread. All this meant that hospitals were no longer merely places in which medical personnel supported patients while nature cured them, but in addition became arenas of active intervention, especially as effective surgical procedures evolved.²

The need to treat an incurable but dangerous disease such as tuberculosis did not fit the emerging acute care hospital model. The function of the new sanatoria was to isolate contagious people, but they were actually run like mental institutions, an observation never made by tuberculosis professionals but obvious to the modern researcher. There is no space here for a comparative history of the mental asylum and the sanatorium; sufficient to note that basic problems and solutions in dealing with long-term patients, many of whom were unwillingly institutionalized, were similar. The importance of a therapeutic environment (including a proper rural site and details of building construction), the moralism inherent in the process by which patients were selected and admitted, the perceived need for a strong charismatic physician-director, the staffing problems and use of patient labor, the lack of definitive

²For the emergence of modern hospitals and medical practice, see Charles E. Rosenberg, The Care of Strangers (New York: Basic Books, 1987), especially chapters 7 - 12; Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), especially Book One, chapters 3 - 5; Morris J. Vogel, "Machine Politics and Medical Care: The City Hospital at the Turn of the Century," in The Therapeutic Revolution: Essays in the Social History of American Medicine, eds. Vogel and Charles E. Rosenberg (U. of PA Press, 1979), pp. 159 - 175.

cure -- all these were common to both kinds of institution.³ Gerald Grob points out that most patients in mental asylums were there because of an "absence of alternatives" for custodial care.⁴ The same could be said of sanatoria.

During the years between Edward Trudeau's establishment of his Adirondack Cottage Sanatorium (1885) and the First World War, physicians, nurses and social workers active in the sanatorium movement published many professional papers in which they described new physical plants and treatment modalities, debated admission policies, reported solutions to staffing problems, tabulated outcome data, and lobbied for legislative action. Drawing on this professional literature, this chapter describes sanatoria and the care given in them to provide background for the following chapters about tuberculosis in Hartford. It suggests that a kind of syllogism emerged: People with advanced tuberculosis were dangerous because they were more infectious than they had been in the earlier stages; poor people were more likely to wait to seek medical attention until their disease was in its late stages; therefore, poor consumptives were dangerous to society. This chain of reasoning affected both medical and public policy.

³See Nancy Tomes, A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-keeping, 1840 - 1883 (Cambridge: Cambridge University Press, 1984).

⁴Gerald Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in Therapeutic Revolution, eds. Morris J. Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979), p. 151.

As physicians devoted much effort to classifying patients by stage of disease, some came to advocate involuntary admission to sanatoria for people with advanced disease who did not obey their dictates about the proper ways consumptives should live. It proved impossible to identify and selectively admit patients in specific disease stages and few states actually enacted laws which permitted health authorities to lock up very ill people. Nevertheless, the literature reviewed here, written by middle class professionals treating consumptives, indicates that they feared poorer, sicker patients and promoted residential care for them in part as a measure to remove them from the community.

TUBERCULOSIS TREATMENT

Although tuberculosis mortality in the United States peaked before 1830 and began to decline after 1880,⁵ the disease remained a major cause of death until the post World War II antibiotic era. In 1908 the death rate from tuberculosis was conservatively calculated at 142 per 100,000, or around one in nine deaths from all causes.⁶ Peak mortality tended to occur in the most productive working and child bearing years: For people in the

⁵Harry F. Dowling, Fighting Infection (Cambridge: Harvard University Press, 1977), p. 71.

⁶Irving Fisher, "The Cost of Tuberculosis in the United States and Its Reduction," Transactions of the Sixth International Congress on Tuberculosis (Philadelphia: William F. Fell Co., 1908) Volume III, pp. 6 - 7. This congress hereafter footnoted as Sixth Congress 1908.

third decade of life, tuberculosis was responsible for one death in three.⁷

Tuberculosis did not kill quickly. Morbidity figures showed that the disease had great social and economic costs; one expert estimated that death occurred after an average of three years of disability.⁸ Calculating the drain on the economy from lost wages and costs of care, theoreticians arrived at staggering numbers. In 1908, the "average cost in actual money of a death from tuberculosis" was multiplied by the number of annual tuberculosis deaths to yield a cost to the nation per year of \$1,100,000,000.⁹ Whatever we may think of the accuracy of such figures, they indicate the felt urgency of the need to stop the spread of the disease.

That tuberculosis was a disease of the poor was considered obvious: "Consumption is the most certain of the numerous blessings of the poor," said one physician, who also reminded his readers that tuberculosis death rates varied directly with social position.¹⁰ The most effective treatment for working class pa-

⁷Ibid., p. 13.

⁸Ibid.

⁹Ibid., p. 34. This author notes (p. 20) that the annual wage for an unskilled male worker was \$300 -- a dollar a working day.

¹⁰Woods Hutchinson, "The Relation Between Income and Tuberculosis," Sixth Congress, 1908 Volume III p. 717.

Physicians occasionally acknowledged that it was also possible for wealthy people to be infected by the bacillus and to be problem patients. According to a tuberculosis specialist in a resort town, the affluent consumptive had difficulty learning to live a healthy life because of an unwillingness to "give up his favorite indulgences." Charles L. Minor, "The Treatment of Tuberculosis Patients

tients, he went on, would be a ten percent increase in wages: "...the consumptive can, roughly speaking, buy as many chances of living as he is able to afford."¹¹

Urban working class families lived on between nine and eighteen dollars a week and tended not to use free dispensaries because they could not afford the wages lost if they took time off to do so. Sanatorium care cost between ten and twenty dollars a week, a sum impossible for such workers to afford. If illness of the primary wage earner, usually the husband, forced the wife to provide for the family alone, weekly income fell to an average of around four dollars -- not enough for minimal food and shelter, especially if there were children in the family.¹²

Many experts published regimens for providing sanatorium-type care at home,¹³ but even this was almost impossible to carry out in an overcrowded tenement apartment. Minimal requirements, that the patient have a bed to him or herself located near a window and should spend as much time as possible outdoors (on the tenement

in their Homes and in Places Other Than Sanatoriums," Sixth Congress 1908 Volume I Part II, pp. 1013-27.

¹¹Hutchinson, pp. 718 - 9.

¹²Sherman C. Kingsley, "The Burdens Entailed by Tuberculosis on Individuals and Families," Sixth Congress, 1908 Volume III pp. 47 - 52.

¹³Lawrence Flick, "Diagnosis and Treatment of Early Cases of Tuberculosis," Sixth Congress 1908 Volume I Part II pp. 631 - 8; Thomas D. Coleman, "The Treatment of Tuberculosis Patients in Their Homes and Places Other Than Sanatoriums," Sixth Congress 1908 Volume I Part II pp. 1030 - 41; Minor, p. 1020; Edward O. Otis, "Home Treatment of Tuberculosis Either in Favorable or Unfavorable Climates," First Meeting NASPTB (New York: Irving Press, 1906), pp. 389 - 98.

roof if there was no yard), were difficult to achieve for the poor.¹⁴

By the turn of the century, efforts had begun to contain the disease. Public health authorities in large cities began to require physicians to report tuberculosis cases in part so that patients could be supervised in their communities.¹⁵ New York City's Health Department lead the country in developing such a program, monitoring and assisting the poor via a dispensary system with nurses and medical inspectors to visit those without private physicians. Consumptives and their families were taught to carry out a program of care which consisted of rest, fresh air and good food. They were also supplied with free "sanitary cuspidors" to dispose of sputum, and sometimes given food supplements (milk and eggs).¹⁶ All these services were intended for the poor. The New York City Board of Health did not send visitors to people who had

¹⁴Coleman, p. 1031 - 2.

¹⁵This was called "notification," and it was a long struggle before private physicians cooperated with city health departments. Issues and strategies were complex and are well summarized by Daniel M. Fox, "Social Policy and City Politics: Tuberculosis Reporting in New York, 1889 - 1900," Bulletin of the History of Medicine 49 (Spring 1975): 169 - 195.

¹⁶Developed first in New York, such programs were copied elsewhere. Most included a wide range of activities -- statistics-gathering, public education, inspection of lodging houses, disinfection of apartments vacated by tuberculous people, anti-spitting regulations, etc. For contemporary descriptions, see: Herman Biggs, "The Administrative Control of Tuberculosis in New York City," Sixth Congress 1908 Volume IV Part I pp. 198 - 202; Samuel Dixon, "The Government Control of Tuberculous Patients in Pennsylvania," Sixth Congress 1908 Volume IV Part I pp. 232 - 9; Marshall Langton Price, "The Statutory Control of Tuberculosis, with Special Reference to the Maryland System," Sixth Congress 1908 Volume IV Part I pp. 209 - 19.

private physicians, assuming that physicians would "see that the necessary precautions are taken to prevent the transmission of the disease to others" for consumptives regularly under their care.¹⁷

Whether at home or in the sanatorium, the basic rules were the same. The patient must expectorate into a container which could be disinfected or burned; as much time as possible was to be spent outdoors; there must be "an abundance of wholesome food"; the patient should be kept warm; surroundings should be cheerful; and finally, there should be "constant medical supervision."¹⁸ While the physician was to be "determined and forceful," the ideal patient was "intelligent, earnest and obedient."¹⁹

Although home care was all that would be available for most consumptives, tuberculosis workers felt sanatoria offered better discipline, fresher air and other patients to provide motivation and companionship.²⁰ Sanatoria were to be "educational centers" to "teach a proper mode of life to the community in general and the consumptive in particular ... [and to spread] the gospel of a life in pure air as the only proper mode of life...."²¹

Another reason such professionals advocated sanatorium care was to isolate people they thought were most contagious. Since

¹⁷Biggs, p. 199.

¹⁸Ibid., p. 1033.

¹⁹Minor, p. 1014.

²⁰Minor, p. 1019.

²¹Theodore Sachs, "Local Sanatoriums and Tuberculosis," Charities 16 (May 26, 1906): 282.

production of infectious sputum increases as the disease progresses, and since poor people tended not to present themselves for care until they were too sick to work, many cases among the working classes and indigent were advanced. Tuberculosis workers identified such people as dangerous to others, most of all to their own families but also to fellow workers and middle class employers. A nurse described the risk to a middle class family when their laundress was part of a consumptive household:

Consider ... the incurable or careless consumptive in a home where laundry ... is the main source of income in winter there must be only one fire, that usually in the kitchen, and often we find the bed of the patient moved into this room The family launder clothes, which are often placed upon this bed before being put into the baskets or parcels to be returned to the owners, who in turn place them ... on their own beds.²²

Another observer framed "The Negro Tuberculosis Problem" in terms of its threat to white people:

The problem of the negro is too intimately bound up with the life of the white man to be neglected or ignored. The negro washerwoman, nursemaid, cook and domestic servant are everywhere present....²³

These authors lobbied for institutions in which to place the terminally ill consumptive for the protection of the community.

SANATORIA

The campaign against tuberculosis in the United States was waged and coordinated by the National Association for the Study and

²²S. H. Cabaniss, "Hospital Care for the Advanced and Incurable Cases of Consumption," Sixth Congress, 1908 Volume III p. 543.

²³"The Negro Tuberculosis Problem," The Modern Hospital 4 (May 1915): 349.

Prevention of Tuberculosis (hereafter NASPTB), organized in 1904.²⁴ The NASPTB never promoted sanatoria as sufficient to treat the consumptive and control the spread of the disease. Nevertheless, sanatoria were key elements in the anti-TB crusade. They provided a means of safeguarding the rest of society by isolating people thought to be most contagious, those with advanced disease. At the same time, physicians, needing arenas in which to demonstrate their science, promoted sanatoria as edifying and healthful settings for those with potentially curable early disease. The ever growing number of sanatorium beds was visible and dramatic evidence of the commitment of philanthropic and/or public funds to the control of tuberculosis.²⁵

²⁴Historians of medicine and the progressive era identify the NASPTB as the prototype of a new form of voluntary organization focused on a specific disease. Concerned people, medical and non-medical, formed local groups which were linked together in regional and national networks. The activities of the NASPTB were many -- educating the public, lobbying for governmental funding, soliciting public and philanthropic giving (the Christmas Seal campaign), providing direct patient services, etc.

For the NASPTB's place in the history of medicine and the progressive era, see John C. Burnham, "Medical Specialists and Movements Toward Social Control in the Progressive Era: Three Examples," in Building the Organizational Society, ed. Jerry Israel (New York: The Free Press, 1972), pp. 19 - 30; Dowling, Fighting Infection; Richard H. Shryock, "The Historical Significance of the Tuberculosis Movement," in Medicine in America (Baltimore: The Johns Hopkins Press, 1966), pp. 139 - 145; Margaret Ellen Kidd Parsons, White Plague and Double-Barred Cross in Atlanta, 1895 - 1945 (PhD Dissertation, Emory University, 1985) and Michael E. Teller, The Tuberculosis Movement: A Public Health Campaign in the Progressive Era (New York: Greenwood Press, 1988).

²⁵William H. Baldwin, "The Progress of the Sanatorium Movement in America, First Annual Meeting of NASPTB (New York: Irving Press, 1906), pp. 71 - 2, 82.

Throughout the early years of the century, states, counties, cities, private charities and profit-seeking medical entrepreneurs continued to construct sanatoria. Their numbers increased dramatically, from twelve in 1899 to 536 in 1925.²⁶ They included experiments such as a "Workmen's Sanatorium for Workers" supported by The Workmen's Circle of a "radical class of Jewish workingmen"²⁷ (some labor unions attempted similar facilities).²⁸ A few employers, such as the Metropolitan Life Insurance Company, erected sanatoria for their own staffs.²⁹ The Pacific States Telephone Company was willing to pay for treatment

²⁶Teller, p. 82; David J. Rothman and Eileen A. Tynan, "Advantages and Disadvantages of Special Hospitals for Patients with HIV Infections," New England Journal of Medicine 323 (September 13, 1990): 765. This does not count many small boarding houses which served consumptive patients and contributed the sleeping porch to American vernacular architecture. For an excellent illustrated discussion of such establishments, see Philip Gallos, Cure Cottages of Saranac Lake (Saranac Lake NY: Historic Saranac Lake, 1988).

Sanatoria came in many architectural forms, from tent colonies to multi-storied pavilions, depending upon location and moneys available. A fascinating topic in itself, it is outside the purview of this paper. Many editions of The Modern Hospital in the teens contain floor plans and photographs of new or proposed sanatoria. Physicians had definite ideas of proper construction methods and plans as well. See, for example, Herbert C. Clapp, "The Function of Municipal Governments in Licensing Private Sanatoriums for Tuberculosis," Sixth Congress 1908 Volume IV Part I pp. 253 - 61; Arnold Klebs, "Economic and Efficient Construction," Fifth Meeting, NASPTB (Philadelphia: William F. Fell Co., 1909), pp. 126 - 141.

²⁷Hyman Strunsky, "A Workmen's Sanatorium for Workers," Survey 34 (May 29, 1915): 196 - 8.

²⁸Lee K. Frankel, "Insurance against Tuberculosis," Sixth Meeting NASPTB (Philadelphia: William Fell Co., 1910), p. 36.

²⁹*Ibid.*

for at least a few workers,³⁰ but this sort of an investment in employee health seems to have been rare in this period. Most facilities with more than a few beds, however, were operated by cities, counties or states. Placing ultimate responsibility for the care of indigent consumptives upon public officials was characteristic of mainstream progressive thought, which identified government as the only source of administrative control and funding large enough to be able to carry out public welfare programs. Voluntary associations such as the NASPTB identified and sometimes initiated model services and programs, but were reluctant or unable to preside over their proliferation.³¹ Public sanatoria were variously funded by cities, counties or states; the distribution of responsibility varied from place to place and over time as more and more facilities were built.

The first state sanatorium opened in 1899 in Rutland, Massachusetts. Herbert Clapp, its medical director, wanted to limit admission to patients who were tough, cheerful, intelligent, possessed "the right moral stamina," and whose symptoms had first appeared within the past three months.³² The privilege of treating only people with early disease was to be granted to few

³⁰Richard C. Cabot, "Arequipa Sanatorium," Survey 29 (December 7, 1912): 313.

³¹Arthur S. Link and Richard L. McCormick, Progressivism (Arlington Heights IL: Harlan Davidson, Inc., 1983) p. 87.

³²Herbert C. Clapp, "What Cases are Suitable for Admission to a State Sanatorium for Tuberculosis, Especially in New England?" First Meeting NASPTB (New York: Irving Press, 1906), p. 344 - 5.

sanatorium administrators. Public sanatoria had to admit advanced patients because people with end stage disease were often unable to afford private care. A 1909 survey revealed that only nine per cent of institutions which accepted advanced cases were self supporting, while 54% of those which claimed to limit admissions to "incipients" were self-sustaining from fees.³³

Even within the public sphere, there were attempts to make each administrative level (state, county, city) responsible for different patients. Debate about which patients should be cared for where went on throughout the period. Resolution was different in each state. Although it is difficult to generalize, a pattern emerged whereby people with advanced disease were admitted to local city or county institutions, while patients who were thought able to recover were sent to state facilities. This was partly because cities or counties had always been responsible for care of the incurably ill in almshouses and poorhouses. There were also economic considerations. Since it cost more to treat early cases, facilities for their care had to be better funded, and there was more money at the state level. The Department of Public Charities in New York City calculated that advanced cases cost sixty one cents per day per patient, as against a dollar a day per capita for those in the early stages. The commissioner of the department

³³A. H. Garvin, "Improved Organization and Management," Fifth Meeting NASPTB (Philadelphia: William F. Fell Co., 1909), p. 142 - 3.

explained that those in early stages needed more food, especially eggs and milk.³⁴

Patients were distributed among institutions differently in different states, but the goal was always to separate them by disease stage. Boston [City] Consumptives Hospital at Mattapan consisted of a day-camp for ambulatory patients who had homes to return to at night, a cottage-hospital for moderately advanced patients, and a hospital for far-advanced or dying patients. The state of Massachusetts operated a sanatorium at Rutland for "incipients." Pennsylvania admitted patients at all stages to each of its three sanatoria but housed them separately. The state of Minnesota and cities of New York and Cleveland also had separate public institutions for early and late stages.³⁵

The primary goal was to keep the advanced patients away from all others; indeed, for some tuberculosis professionals, the whole

³⁴Homer Folks, "Municipal Sanatorium for Incipient Cases of Tuberculosis," Charities 11 (July 18, 1903): 71. The experience at Hartford Hospital was different; there, it cost more to care for the advanced cases in the hospital proper than for the incipients in the sanatorium. See Chapter III, below.

³⁵For Massachusetts, Edwin A. Locke and Simon F. Cox, "The Municipal Hospital for Advanced Consumptives in Boston," Sixth Congress 1908 Volume I part II, pp. 988-95; Clapp, "What Cases are Suitable," p. 339; John B. Hawes, "The Present Situation in Regard to Local Tuberculosis Hospitals," Boston Medical and Surgical Journal 193 (August 12, 1915): 251. For Pennsylvania, Karl Schaeffle, "Pennsylvania an Example of the Advantages of State Wide Control of Tuberculosis," The Modern Hospital 10 (January 1918): 17-21. For Minnesota, H. Longstreet Taylor, "Advantages of State Control Over Tuberculosis Hospitals," The Modern Hospital 3 (July 1914): 35. For New York, Biggs, p. 200-01. For Cleveland, Clyde E. Ford, "The Responsibility of the City in the Tuberculosis Problem," Seventh Meeting NASPTB (Philadelphia: William Fell Co., 1911), p. 60.

reason for publicly supported institutions was to isolate advanced patients. For example:

The advanced phthisis patient ... in almost every instance becomes ... a danger to his family and a center of contagion for his surroundings The unfortunate sufferer ... should no longer be left free to choose whether or not he will leave his home, but should be made to enter a hospital or sanatorium the duty of making sufficient provision for the great number of advanced consumptives ... should fall upon the state, and it were well if the private hospital withdrew entirely from the care of the advanced consumptive.³⁶

In reality, much of the discussion about disposition of patients with varying degrees of tuberculosis was academic. Making an accurate diagnosis of the stage of pulmonary tuberculosis was quite difficult,³⁷ and in fact, as will be seen below, most sanatoria ended up with a mixture of patients. Dr. Vaughan of Detroit was unusually candid when he admitted that in his city, patients in various stages were mixed in the same institution, a practice for which he said he had been "criticized extensively."³⁸ The important point is that the rhetoric of health care professionals emphasized that it was possible and desirable to recognize different stages of tuberculosis, and that patients in the same stage should be housed together.

³⁶Jacob H. Schiff, "Institutional Care for Early or for Advanced Consumptives?" Sixth Congress, 1908 pp. 362-3.

³⁷Edward O. Otis, "The Early Recognition of Tuberculosis", pp. 353 - 4. Apparatus to take x-rays and expertise to read them were still rudimentary, as were laboratories to process and read sputum samples.

³⁸Ibid.

Since tuberculosis cases identified as "advanced" also happened often to be urban poor people, the resultant corollary was that they were feared as dangerous foci of infection. To tuberculosis workers, they were difficult to treat "owing to their inability to put into practice customs and habits alien to all their past training."³⁹ Tenement dwellers were not able to maintain standards of personal cleanliness deemed necessary by health professionals;⁴⁰ often immigrants, their ethnic foods were not identifiable to middle class observers as nutritious and they could not afford the amounts thought necessary. They especially lacked those most important middle class characteristics, self control and willingness to obey their physicians.⁴¹

Physicians, nurses and social workers found it difficult to distinguish between consumptives unable to care for themselves and those unwilling to conform to middle class norms: "[T]he most dangerous patients are those who are ignorant of the rudiments of personal hygiene, or who have reached such an advanced stage ...[that] they have become helpless, and are unable to take care

³⁹Ibid., p. 1023.

⁴⁰Tomes, "The Private Side of Public Health." The perceived connection between dirt, germs, disease and class are usefully tied together in this paper and even more in the same author's Mss. prepared for the 1991 meeting of the Organization of American Historians, "The Wages of Dirt Were Death: Women and Domestic Hygiene, 1880 - 1930."

⁴¹The ideal patient was even supposed to suppress his cough: "It is remarkable how much this may be done by an effort of the will ... shown by the small amount of coughing to be heard in any well-regulated tuberculosis sanatorium." Coleman, p. 1038.

for [sic.] their expectionation."⁴² Some middle class workers thought poverty was synonymous with mental dullness. "The day-laborer, the shop-girl, the drunken negro belong to a class that ... is unable to make use of what it learns."⁴³ Furthermore,

People of this class are by nature weak, shiftless, and lacking in initiative and in perseverance. They have neither inherited nor acquired moral strength ... and they are often vicious besides. It takes a high grade of moral fiber to maintain the persistent and long-drawn struggle that must be kept up in fighting tuberculosis, and they have not the self-control necessary No amount of education in the laws of hygiene can give them moral fiber, nor can they be trained to exercise self-control in time to do any good.⁴⁴

From accusation of lack of "moral strength" to application of the "vicious" label was a short step. A New Haven physician recommended that as soon as consumptives were "thrown upon public charity," they should "be at once removed to a detention institution." Jail was the only appropriate placement for "vicious" consumptives who "intentionally defy the rules that have been established for their control."⁴⁵ In the discussion which followed, "vicious" was defined by another physician: "...the slum-dweller, by which I mean the hopelessly idle, vicious, worthless

⁴²C. D. Spivak, "Isolation of Advanced Consumptives," Charities 16 (May 26, 1906): 279.

⁴³Ellen N. La Motte, "The Unteachable Consumptive," Sixth Congress 1908 Volume III p. 256.

⁴⁴Ibid., p. 258.

⁴⁵John P. C. Foster, "Detention Institutions for Ignorant and Vicious Consumptives," First Meeting NASPTB (New York: Irving Press, 1906), pp. 334 - 7. It is probably not coincidental that Foster was the executive director of a private sanatorium (Gaylord, in Wallingford CT) who later chaired the commission which advocated Connecticut's state sanatorium system.

and uneducated poor...." He suggested that state sanatoria were appropriate only for the "worthy laboring class," since the "uneducated poor" would "relapse into the filthy habits, unsanitary methods of living, and vicious practices which have in the first instance made them sick, and thus the money of the State will be thrown away and the opportunities for cure and instruction of the more worthy poor will be lessened."⁴⁶ Dr. Otis of Boston expressed a minority view when he said, "...not all the poor consumptives are of the 'slummy' character. They are decent working people, many of them, and I do not think we should place them in the same class as vicious consumptive."⁴⁷

The identification of poor or indigent people as "other," who were responsible for their own disease because they did not behave in ways familiar to middle class reformers, is part of a nativist, xenophobic perception of the world common in the United States at the turn of the century. Echoes of it can be found throughout the tuberculosis literature. The November 7, 1908 issue of Charities ran a series of articles about TB among Indians, Jews, Negroes, Scandinavians, Sioux Indians, Italians and Irish. Readers learned that [Native American] Indians ate from wooden and gourd dishes that could not be properly cleaned, "spit freely" on the sandy

⁴⁶"General Discussion of the Symposium on Sanatorium Treatment and Other Papers," First Meeting NASPTB (New York: Irving Press, 1906), p. 403.

⁴⁷Ibid., p. 404.

floors of their dwellings, and generally led unsanitary lives.⁴⁸ Jews had lower mortality rates because they had been city dwellers for two thousand years and had adapted to the urban milieu.⁴⁹ Italians, accustomed to rural life, became ill and died rapidly when exposed to strenuous work in dirty trades, repeated pregnancies and insufficient food in urban environments.⁵⁰ Negroes lived crowded together and had "pernicious sanitary habits," and a "childish want of self-control."⁵¹ Scandinavians were intelligent and moral and tended to settle in rural districts but "despise fresh air ... and live with the doors and windows closed." They had a low general death rate but a relatively high tuberculosis mortality rate.⁵² The Irish were "hyper-susceptible" and had "hypo-immunity" because the "race" had not been long exposed to tuberculosis.⁵³ Another observer warned that "Chinese, Negroes, Bohemians and Irish suffer more and are consequently a greater

⁴⁸Ales Hrdlicka, "Tuberculosis in the Indian," Charities 21 (November 7, 1908): 245 - 7.

⁴⁹Maurice Fishberg, "[Tuberculosis] Among the Jews," Charities 21 (November 7, 1908): 248.

⁵⁰Antonio Stella, "[Tuberculosis] Among the Italians," Charities 21 (November 7, 1908): 248.

⁵¹Robert Wilson Jr, "[Tuberculosis] Among the Negroes," Charities 21 (November 7, 1908): 248.

⁵²George Douglas Head, "[Tuberculosis] Among the Scandinavians" Charities 21 (November 7, 1908) p 249

⁵³Lawrence F. Flick, "[Tuberculosis] Among the Irish," Charities 21 (November 7, 1908): 249 - 50.

menace ... to the community than are the Jews and the Italians."⁵⁴ This sense that the illnesses of the poor were made more dangerous by modes of living which made it easy for disease to spread among them (and by implication throughout the entire citizenry) was fostered by a shift in the attention of public health authorities from environmental projects such as sewer systems and clean drinking water to the control of specific contagious diseases. As one public health official put it, "the fight must be won, not by the construction of public works, but by the conduct of the individual life."⁵⁵ Acceptance of the germ theory brought with it much advice to the public, especially women, about how to run healthy homes and raise strong children. Cleanliness, both of the person and of the home, was promoted as essential to disease prevention.⁵⁶ The NASPTB's extensive education program stressing how people could protect themselves from tuberculosis by living properly was part of the same change in public health focus. A combination of nativism and the assumption that the poor wilfully disregarded such attempts to teach them simple measures to stay healthy underlay the "vicious consumptive" label.

⁵⁴Miss Brandt, "Statistics on Tuberculosis," Charities 2 (July 25, 1903): 91 - 2.

⁵⁵Charles E.A. Winslow, The Evolution and Significance of the Modern Public Health Campaign (New Haven: Yale University Press, 1923), p. 55. See also Barbara Rosenkrantz, Public Health and the State (Cambridge: Harvard University Press, 1972), Chapters 4, 5.

⁵⁶Tomes, "The Wages of Dirt Were Death."

If consumptives would not accept institutionalization to protect those around them, thought some physicians and legislators, there should be laws to force them to do so. Compulsory isolation or quarantine of those with communicable diseases had been practiced since the early days of the republic. The former pest houses, now communicable disease hospitals, however, were for acutely infectious diseases such as smallpox, diphtheria and typhoid and did not admit patients with tuberculosis.⁵⁷ By 1910, articles had begun to appear in medical journals reporting approvingly upon a variety of government regulations which were to restrict the movements of consumptives. Although some physicians objected that this would merely lead to concealing the disease, others argued for even more strict measures, among them the "forcible removal, if necessary, of consumptives dangerous to the public from disobedience or unavoidable overcrowding."⁵⁸ By 1912, New Jersey and Maryland had statutes which permitted their boards of health to obtain a court order to commit any offender against the tuberculosis rules and regulations.⁵⁹ The physician reporting upon this legislation recommended that compulsory removal and detention should be available to health officers whenever

⁵⁷Harry F. Dowling, "Patients Behind Glass Walls: The History of the Chicago Municipal Contagious Disease Hospital," Journal of the History of Medicine and Allied Sciences 40 (October 1985): 440 - 443.

⁵⁸Dixon, p. 233; Victor Vaughan, "Tuberculosis Legislation," Fifth Meeting NASPTB (Philadelphia: William F. Fell Co., 1909), pp. 44-45, 54.

⁵⁹Bertram Waters, "Adequate Hospital Control," Eighth Meeting NASPTB (Philadelphia: William F. Fell Co., 1912), p. 248.

- a. There is refusal to comply with sanitary regulations.
- b. Unsanitary home conditions exist.
- c. The patient is of vicious character and habits.
- d. Others, especially children, are exposed to infection.
- e. The patient, or the family, are public charges or dependent upon charitable aid.

Furthermore, such detention should be permanent if necessary.⁶⁰

In the discussion which followed his paper, most colleagues agreed with the necessity for compulsory removal, though several qualified their statements with expressions of concern that the power not be abused: "we have no right to legislate against a consumptive because he is dependent," said one.⁶¹ Others noted that the power to admit a patient to a sanatorium against his will did not always carry with it the authority to keep him there -- some homeless men had been in the New York City tuberculosis hospitals twelve times in as many months.⁶² In 1915, bills permitting involuntary committal were being considered in five states and the District of Columbia.⁶³

In Massachusetts and probably other states as well, local health officials were able to institutionalize "incorrigible consumptives" even without specific state regulations permitting them to do so. Health officers simply assumed more power "in

⁶⁰Ibid., pp. 248 - 9. The list is presented in this form in the original. Waters makes an attempt to safeguard the patient when he suggests that, if bacilli do not appear on a sputum smear, the diagnosis should be confirmed by "two competent examiners."

⁶¹Ibid., p. 252. Discussion following Waters' paper.

⁶²Ibid., p. 256. Discussion following Waters' paper.

⁶³"Tuberculosis Laws," The Modern Hospital 4 (April 1915): 274
- 5. I was unable to discover how many of them were passed.

certain cases when the health of the community is at stake than the strict letter of the law allows them to,"⁶⁴ reported a Boston physician proudly. Such assumption of authority seems never to have been openly challenged. There were other methods -- recipients of public aid could be cut off from payments until they reformed, for example.⁶⁵ Unfortunately, as a physician in charge of a state institution pointed out, such patients were not welcomed in sanatoria or hospitals with "willing patients;" they often remained "incorrigible" and had to be discharged back to their communities.⁶⁶

THE SANATORIUM EXPERIENCE

Papers written by care givers never described the sanatorium patient's actual experience. They occasionally provided readers with accounts of daily routine, usually described as alternating periods of eating and resting with occasional mild activity.⁶⁷ We must therefore make inferences about everyday life in sanatoria and how patients felt about being there by reading between the lines of papers discussing other matters.⁶⁸

⁶⁴Edward O. Otis, et. al. "How May the Best Results Be Obtained in the Care of the Incorrigible Consumptive in Towns Where There Are No Hospitals?" American Journal of Public Health 4 (December 1914): 1205.

⁶⁵Ibid.

⁶⁶Ibid., pp. 1206 - 8. Discussion of Otis' paper.

⁶⁷Locke and Cox, p. 994.

⁶⁸Barbara Bates, Bargaining for Life: A Social History of Tuberculosis, 1876 - 1938 (Philadelphia: University of Pennsylvania Press, 1992) is an excellent secondary source for such descriptions. She had access to the personal papers, including

While some private institutions could be resort-like, parsimonious officials usually saw to it that public sanatoria were starkly utilitarian. Even the site sometimes had to be chosen on grounds of availability and economy. Chicago's first tuberculosis camp (the aim of which was to demonstrate how little money had to be spent to achieve health for incipient patients) was built on the same property as the almshouse and insane asylum⁶⁹-- hardly the serene rural setting advocated by sanatorium experts. Accommodations varied from facility to facility; some were deliberately rough and primitive tents or "lean-tos" which provided minimal shelter from the elements.⁷⁰

Even if physical environments were aesthetically pleasant, sanatoria were seldom pleasant places in which to live. At the simplest level, patients were bored -- sometimes physicians forbade even reading, and there was little in the way of organized entertainment or activities to help.⁷¹ Patients missed and worried about their families. When women and children residing in a preventorium⁷² near a New York City sanatorium were allowed to

letters written by patients and their families, of Dr. Lawrence Flick, an early tuberculosis physician in Philadelphia who established a sanatorium and a research hospital.

⁶⁹"Tuberculosis Camp in Chicago," Charities 16 (September 22, 1906): 609.

⁷⁰Klebs, pp. 131 - 5.

⁷¹John A. Hornsby, "A Need in Tuberculosis Hospitals," The Modern Hospital 3 (November 1914): 315 - 7.

⁷²Preventoria were camp-like residential facilities in which people thought to be at risk for developing tuberculosis could be made healthy by a regimen of good food, rest and fresh air. They

visit their husbands/fathers, a physician noted "...the beneficial influence ... [on] the patient when he ... can see for himself that his family, though deprived of his care, are [sic.] not in want."⁷³ Some consumptives found the socio-economic and ethnic mix in large institutions a shock.⁷⁴ This must have been a problem for many immigrants who came from mono-lingual ghettos in large cities. Finally, and most difficult to bear, the care providers were often rude. The physician in charge of a large institution for the poor admitted apologetically:

I have occasionally had to reprove an ... interne because he seemed to forget that his hospital patient was anything more than an interesting study; and ... it has sometimes seemed to me as though occasionally [a] ... social worker looked on the same class of patient as a sociological curiosity, rather than as a human being.⁷⁵

Florence Burgess, nurse in charge of Connecticut's Gaylord Sanatorium from 1904 until her death in 1935, offers a good example of the mind-set that professionals often brought to their work.

were especially promoted as places to which poor inner city children could escape in the summer -- the forerunners of today's "fresh air camps."

⁷³S. A. Knopf, "The Modern Warfare Against Tuberculosis as a Disease of the Masses," New York Medical Journal 100 (October 3, 1914): 655.

⁷⁴Arthur K. Stone, "Some Problems of the Trustees of Massachusetts Hospitals for Consumptives," Boston Medical and Surgical Journal 175 (October 12, 1916): 533. There were private sanatoria run by religious organizations for their own communicants, of course; Strunsky describes a political/religious institution run by and for "radical Jews."

⁷⁵Walter Sands Mills, "Tuberculosis Infirmary of the Metropolitan Hospital" Charities and the Commons 21 (March 27, 1909), p. 1262.

She thought it her responsibility to provide the atmosphere of "refinement and culture" her patients needed to get well. She suggested nature studies (bringing a flower to each bed patient), recommended that nurses read "good literature" aloud to their patients, and advocated decorated china and tray cloths so the food would be attractively presented. It was the task of the nurse to see that the sanatorium experience be a civilizing influence. "There is no reason why sanatoriums should resemble prisons [each patient] should return home with a knowledge of the essentials of a true home life."⁷⁶

At least Miss Burgess attempted to make patients' time in the sanatorium interesting and pleasant. That her efforts were not practiced in most sanatoria is evident from an angry indictment of public institutions by Samuel Wolman, a dispensary physician. Their well-known shortcomings included poor food served in an unappetizing manner on a weekly schedule of "nauseating monotony." Worse, insufficient staff resulted in reliance upon forced patient labor (disguised as therapeutic exercise) for sanatorium maintenance.⁷⁷ Wolman was furious that his patients were often admitted to sanatoria which were actively harmful.

⁷⁶Florence R. Burgess, "Sanatorium Atmosphere," Sixth Congress 1908 Volume III, p. 519.

⁷⁷Samuel Wolman, "A Criticism of Tuberculosis Sanatoria," Survey 39 (November 17, 1917): 165 - 8. On the benefits to the institution of "therapeutic exercise," see M.S. Paterson, "Graduated Labor in Pulmonary Tuberculosis," Sixth Congress 1908 Volume I part II p. 894; A.H. Garvin, "Improved Organization and Management," Fifth Meeting NASPTB (Philadelphia: William F. Fell Co., 1909), pp. 142-7. Bryder, Below the Magic Mountain, pp. 54 - 67 discusses the practice in Britain, where it originated.

Wolman's charges were substantially accurate. The fear of tuberculosis was so great and the rewards for working with consumptives so few that some nurses refused to care for tuberculosis patients, in or out of sanatoria.⁷⁸ If conditions in sanatoria were unpleasant for patients, they were equally so for staff, which in this period was almost always required to be residential.⁷⁹ Nurses often had to double as housekeepers, a practice against which they protested, but finding sufficient reliable low level workers was difficult.⁸⁰ Officials sometimes were unable to recruit even medical directors; physicians disliked working with advanced patients because it was "uninteresting." Outcome statistics were better in institutions which admitted only incipient cases, and the work was more rewarding and easier.⁸¹ A nurse suggested that advanced patients needed the same kind of attention lepers did, for the same reason: "Our lepers are nursed and cared for, not altogether out of sympathy, but because they constitute a menace to the community."⁸² With attitudes such as

⁷⁸Stella Fewsmith and Louise Croft Boyd, "The Nurse and the Tuberculosis Patient," Sixth Congress 1908 Volume III p. 520.

⁷⁹Hornsby, p. 316.

⁸⁰Otto R. Eichel, "County Tuberculosis Hospital Problems," Thirteenth Meeting NASPTB (New York: J.J. Little and Ives Co., 1917), p. 457.

⁸¹George J. Nelbach, "Some Problems of County Tuberculosis Hospitals," Thirteenth Meeting NASPTB (New York: J.J. Little and Ives Co., 1917), p. 454.

⁸²Harriet Fulmer, "The Importance of Nursing and Supervision of Advanced Cases of Tuberculosis," Sixth Congress 1908 Volume III p. 548.

that, it is not surprising that administrators had to turn to the patients themselves for staffing.

The boundary between staff and patients in almshouses and mental institutions had been fuzzy throughout the nineteenth century. Part of the process of the development of general hospitals in the twentieth century was the definition and maintenance of the line between professionals and their patients.⁸³ Medical directors wanted sanatoria to be perceived as more like hospitals than almshouses or mental institutions; using patients as staff did not fit the image they wished to project.

One solution to the problem was to turn patients into staff by providing "training." This was made more palatable by the difficulty ex-patients had in finding employment upon discharge -- those trained to be tuberculosis nurses at least had a chance to be self supporting. The prestigious Henry Phipps Institute in Philadelphia offered a two-year training program as early as 1904. The practice of using "arrested cases of tuberculosis as attendants" was not new, the physician in charge noted. He listed other advantages as well: It would give such ex-patient nurses a "longer period of residence under good conditions." Patients would respond better to nurses who were first-hand examples of the benefits of adhering to the therapeutic regimen. It would cost the institution less. There were not enough regular nurses with either the training or the inclination to work in sanatoria. Nurses trained

⁸³Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), p. 159.

at Phipps would not compete with "regular" nurses, since they would be prepared only for the nursing of tuberculosis. Of the nineteen nurses who had been graduated from the program, he reported, seventeen were employed, one was dead and one was ill -- encouraging statistics.⁸⁴

The lack of nurses persisted, and nurse-training programs were offered in many sanatoria. A 1922 discussion about how to secure the "best type" of nurse revealed that for the most part, general hospitals did not train nurses for work with tuberculosis patients. Speakers unanimously approved nurse-training by sanatoria and noted that such programs were popular despite "all the disadvantages of dealing with patients, the limited field, and the difficulties as to the class of certificate which could be offered to girls taking this training...."⁸⁵

The point about the "class of certificate" indicates that the women trained in sanatoria as tuberculosis nurses were probably able to find jobs only in such institutions. In effect, sanatoria with training programs had a captive labor force which must have

⁸⁴Charles J. Hatfield, "Training for Professional Nursing in Institutions for Tuberculosis Patients," Sixth Congress 1908 Volume III pp. 407 - 11. See also Bates, chapter 11.

⁸⁵"Informal Discussion of Problems of Tuberculosis Sanatorium Administration," Transactions of the Eighteenth Annual Meeting of the National Tuberculosis Association (New York: NTA, 1922), p. 729.

Other levels of personnel were trained at sanatoria as well. There was a six-month training program at Gaylord to train ex-patients as attendants because of the lack of nurses. See David Lyman, "The Work of the State Tuberculosis Commission, Its Development and Present Outlook," Proceedings of the Connecticut State Medical Society (New Haven: CT State Medical Society, 1915), pp. 203 - 3.

had very little bargaining power. Some fortunate ex-patients who had been trained as nurses were able to open boarding houses for consumptives who were unwilling or unable to be admitted to sanatoria.⁸⁶ Such opportunities were limited, however, to those with capital to invest. Most sanatorium-trained nurses were unable to move about in search of better jobs and had to accept whatever pay and working conditions they were offered.

OUTCOMES

Demographers do not know why the tuberculosis mortality rate fell steadily throughout the late nineteenth and early twentieth centuries. General improvements in sanitation and public health, coupled with increasing prosperity and the resulting improvements in diet and housing account for some of the general improvement in health in those years. Specific anti-tuberculosis interventions, however, cannot be linked to downward mortality curves.⁸⁷

⁸⁶Bates discusses options for TB nurses throughout her book, especially in Chapter 11. Gallos describes the great diversity of non-hospital enterprises in a resort town with a nearby sanatorium. He indicates that some boarding houses specialized in serving specific ethnic groups or disease stages.

⁸⁷Gretchen Condran, Henry Williams and Rose Cheney, "The Decline in Mortality in Philadelphia from 1870 to 1930: The Role of Municipal Services," in Sickness and Health in America, eds. Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1985), p. 427. One modern historian insists that public health measures to isolate people with the disease were responsible for the decrease in mortality. See Leonard G. Wilson, "The Rise and Fall of Tuberculosis in Minnesota: The Role of Infection," Bulletin of the History of Medicine 66 (Spring 1992): 16 - 52. He may be right for as far as his case of a scattered, rural population in Minnesota goes, but I doubt his arguments can be generalized to large urban areas.

Did institutionalization work, if only because patients were placed in environments in which their bodies could heal themselves? Politicians, physicians and patients all asked this question in the first decades of the sanatorium movement. Sanatorium administrators produced statistics to prove that institutionalization did work, but the numbers they published are very difficult for modern researchers to interpret. Criteria for categories of disease severity on admission and discharge, a common way of measuring the success of treatment, were ill-defined. There were no controls. Many institutions did not even bother to keep statistics. The American Sanatorium Association attempted a coordinated follow-up study in 1922. Of seven hundred sanatoria, only 43 sent usable data; of those only 20 could track more than 50 percent of discharged patients. One of the researchers understandably wondered if the study should be continued since so few sanatoria could afford the clerical help necessary to do follow-ups on patients.⁸⁸ Thus, statistics in the few published papers which will be cited below should be read as tentative. They were probably intended to be as much propaganda as scientific reporting.

The first thing one notices in seeking outcome data is that very little was published; only six such studies could be found in the period reviewed. Further, sanatorium officials based their calculations of results on the number of patients discharged alive.

⁸⁸J. S. Whitney, "Report of the Sanatorium Follow-Up Study of the National Tuberculosis Association," Transactions of the Eighteenth Annual Meeting of the National Tuberculosis Association (New York: NTA, 1922), pp. 720 - 1.

Most did not mention mortality within the institution; in a rare exception, Metropolitan Hospital's tuberculosis infirmary, where the patients were "of the poorest, financially and physically," reported that 30 percent died, half of them within a month of admission.⁸⁹ At the Metropolitan Life Insurance Company's sanatorium for its (middle class) employees, 6.4 percent died while institutionalized,⁹⁰ a figure which seems consistent with others. A 6.3 percent death rate was reported for Loomis, another private facility,⁹¹ and 5 percent for the Massachusetts state system.⁹² All the statistical reports of sanatoria other than Metropolitan Hospital, however, did not count patients who stayed less than thirty days, which leaves us without information about deaths occurring soon after admission.

Death was not the only reason for people to drop out of sanatoria within the first month. Although the data is scanty, it seems that substantial numbers of patients discharged themselves for a variety of reasons. The physician who ran an 800 bed city infirmary for advanced diseases commented,

⁸⁹Mills, pp. 1262 - 3.

⁹⁰Horace J. Howk, Louis Dublin and Inger Knudsen, "The After-History of Nine Hundred and Fifty-Three Tuberculosis Patients Discharged from the Metropolitan Life Sanatorium from 1914 to 1920," Transactions of the Eighteenth Annual Meeting of the National Tuberculosis Association (New York: NTA, 1922), p. 274.

⁹¹Herbert Maxon King, "A Preliminary Study of the Value of Sanatorium Treatment," Eighth Meeting NASPTB (Philadelphia: William Fell Co., 1912), p. 86. He gives the number, 63 of 995. I calculated the percentage.

⁹²Gertrude L. Farmer, "Is Sanatorium Treatment Worth While?" Boston Medical and Surgical Journal 170 (March 19, 1914): 414.

I was asked ... what became of the 10,589 patients discharged [in the seven years the infirmary had been open]. A few were cured. The vast majority left at their own request; some because they felt well enough to return to work, some to go to other institutions, some to indulge in their pet dissipations, some because they were homesick and wished to go home.⁹³

Another author summarized reasons that fifty patients gave for leaving Massachusetts state sanatoria. "Dissatisfied with sanatorium," "objected to treatment," "homesick," "home or business conditions," "discouraged" and "misconduct" account for half of them.⁹⁴ It is fair to conclude that sanatoria were not popular places.

When reporting upon outcomes of patients who completed treatment, sanatoria administrators revealed a preoccupation with labelling the stage of disease, probably due a desire to demonstrate that patients could improve. Upon admission, the disease status of each patient was classified as "incipient," "moderately advanced," "advanced." "Stage I, II, III" and "early" and "late" were other terms used. When discharged, the patient's condition was relabeled as "apparently cured," "arrested," "improved," "unimproved." Criteria by which labels were applied were not provided, and the labels themselves varied from institution to

⁹³Mills, p. 1263.

⁹⁴ Farmer, p. 414. Other reasons given are "insufficient evidence of tuberculosis," "too far advanced," "pregnant," "lack of funds," "neurasthenic," "came for education," "to follow treatment at home." Many gave no reason at all.

MAIN SANATORIUM CHART 2. MALES AND FEMALES—407 PATIENTS DISCHARGED ALIVE FROM MAIN SANATORIUM
INCIPIENT CASES, 57=14 PER CENT. OF 407

Condition on Oct. 31, 1911.....	HEALTH SATISFACTORY					HEALTH UNSATISFACTORY					STATUS DOUBTFUL					DEAD					TOTALS	
Condition on Dis- charge.....	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	Apparently Cured,	57=61.40% of 57
	74.28	60.23	77.77	...	73.68	8.57	...	11.11	...	7.01	9.85	7.60	3.50	44.28	23.07	13.11	...	15.70	Arrested,	15=22.80% of 57
Number of Patients	26	9	7	...	41	3	...	2	...	4	1	1	2	5	3	1	...	9	Improved,	9=15.70% of 57
																					Unimproved,	0

MODERATELY ADVANCED CASES, 128=31.44 PER CENT. OF 407

Condition on Oct. 31, 1911.....	HEALTH SATISFACTORY					HEALTH UNSATISFACTORY					STATUS DOUBTFUL					DEAD					TOTALS	
Condition on Dis- charge.....	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	Apparently Cured,	35=27.34% of 128
	71.42	48.80	77.02	9.09	45.31	5.71	8.88	5.41	...	6.25	8.57	4.44	8.10	...	6.25	14.28	37.78	59.46	90.90	49.38	Arrested,	45=35.15% of 128
Number of Patients	25	22	20	1	58	2	4	3	...	8	3	3	3	...	8	5	17	22	10	54	Improved,	37=28.90% of 128
																					Unimproved,	11=8.59% of 128

FAR-ADVANCED CASES, 222=54.54 PER CENT. OF 407

Condition on Oct. 31, 1911.	HEALTH SATISFACTORY					HEALTH UNSATISFACTORY					STATUS DOUBTFUL					DEAD					TOTALS	
Condition on Dis- charge.	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	C.	A.	I.	U.	Total	Apparently Cured,	6 = 2.70% of 222
	83.33	57.77	5.43	1.13	9.45	..	5.35	7.60	..	4.05	..	4.34	1.13	2.25	16.66	66.66	81.63	97.72	84.33	Arrested,	36 = 16.21% of 222	
Number of Patients.	5	10	5	1	21	..	4	7	..	9	..	4	3	5	1	3	24	76	86	187	Improved,	92 = 41.44% of 222
Totals.	73.68	43.61	15.04	1.09	30.75	6.37	6.38	7.24	..	5.15	5.26	3.10	5.07	1.01	3.68	14.47	46.80	21.73	96.96	61.43	Unimproved,	88 = 39.63% of 222
	36	41	12	1	121	5	6	10	..	21	4	3	7	1	15	11	44	90	96	250		

Total Apparently Cured, 76=18.67% of 407. Total Arrested, 94=23.09% of 407. Total Improved, 138=33.90% of 407. Total Unimproved, 99=24.32% of 407.

Figure 1: Outcome Statistics as Presented in 1912.

One of seven pages of tables in Herbert Maxon King, "A Preliminary Study of the Value of Sanatorium Treatment," Eighth Annual Meeting of the National Association for the Study and Prevention of Tuberculosis (Philadelphia: William Fell Co., 1912), p. 94.

institution and over time.⁹⁵ Data was presented by classification in lengthy and complex tables, an example of which is reproduced in Figure 1, opposite. This is one of seven pages of tables, each of which requires two additional pages of text to explain it!⁹⁶ Numbers such as these are meaningless even as measures of the predictive power of the initial categories.

Given the desire to prove the success of their facilities, especially if success was defined as improvement rather than cure, it is surprising that none of the sanatorium directors providing outcomes correlated condition at discharge with length of stay in the institution. In fact, few mentioned length of stay at all. Those that did indicated that around six months was the average.⁹⁷ "Bottom line" statistics -- reported survival rates -- varied widely but do not support the notion that sanatoria were successful in achieving cures, though there are no comparative

⁹⁵Edward R. Baldwin, "Annual Report of the Chairman of the Executive Committee of the Board of Trustees of the Trudeau Sanatorium," Thirtieth-Third Annual Report of the Trudeau Sanatorium (Saranca Lake NY, November 1917), p. 6.

⁹⁶King, p. 91.

⁹⁷Farmer gives a range of 5.25 to 6.50 months and comments that this is too short [Farmer, p. 415]. Billings and Hawes, also of the Massachusetts state system, say their subjects stayed an average of slightly over 6 months. [Bernice W. Billings and John B. Hawes, "Are Sanatoria Worthwhile?" Thirteenth Annual Meeting of the NASPTB (New York: J.J. Little & Ives Co., 1917), p. 205] Baldwin's Trudeau Sanatorium patients stayed an average of five months and eighteen days in 1917, which, he comments, was shorter than in the past. [E. Baldwin, p. 7.] At the Metropolitan Life Insurance Co. sanatorium for employees, stays ranged between 7 and 14 months and averaged almost 10 months. Patients were evidently kept until completely well, as the author comments that the interval between discharge and resuming work was usually around a week. [Howk et. al., pp. 272-3.]

rates available for matched non-institutionalized patients. The only studies published between 1908 and 1919 which gave such figures indicate that survival rates varied between a low of 18% over 20 years and a high of 68% after six years.⁹⁸ By present standards these studies are flawed because they do not follow each cohort of patients separately, but lump together those recently discharged with those out for many years. The fall-off after discharge may have been rapid: Results of the only study which followed the same cohort of people found that forty-five percent were dead within two years.⁹⁹ Statistics such as these would not be considered an advertisement for the efficacy of therapy today, but we have no way of knowing how they were received by either patients or physicians in their time. Such data raise more questions than they answer.

Although the numbers we have are not useful for statistical calculations, they are important because they contradict the prescriptive literature about patient selection. No matter what their official admission policies were, all institutions, public and private, which provided numerical outcomes reported patients in all categories of severity; most had more "advanced" than

⁹⁸See: Lawrason Brown, "The Ultimate Results of Sanatorium Treatment," Transactions of Sixth International Congress, 1908 Vol I Part II p. 937 - 8; Edwin Locke and Cleaveland Floyd, "An Economic Study of 500 Consumptives Treated in the Boston Consumptives" Hospital", Seventh Meeting NASPTB (Philadelphia: William Fell Co., 1911), p. 149; Fred H. Heise, "The Condition of patients Twenty Years After Discharge from the Trudeau Sanatorium," American Review of Tuberculosis 3 (October 1919): 499; King, p. 87; Farmer, p. 414; Billings and Hawes, p. 204.

⁹⁹Billings and Hawes, pp. 204-5.

"incipient" cases. In the Massachusetts state sanatoria which were said to be for "incipient" patients only, between 1906 and 1912 only 36 percent of admissions were categorized "incipient."¹⁰⁰ Even private facilities are shown to have been unable to restrict admissions to the early stages; of the patients discharged alive between 1902 and 1911 from Loomis, a mere fourteen percent had been admitted as "incipient."¹⁰¹ In 1913, the superintendent of an Iowa state sanatorium which was supposed to be limited to early cases complained that only nineteen percent of live discharges had been admitted in the "incipient" category. In what was probably common practice, instead of limiting admissions, he had "kept the institution as full as [he] could...."¹⁰² Thus, it appears that sanatoria were in fact places for patients with late disease despite their supposedly greater effectiveness in treating people in the earlier stages.

CONCLUSION

The tuberculosis sanatorium as a place for custodial care of the chronically ill did not fit the acute care hospital model which was emerging in the first decade of the century. Since status among physicians was increasingly associated with hospital affiliation, those staffing sanatoria tried to make their institutions seem more like hospitals. This explains the attention

¹⁰⁰Farmer, p. 414.

¹⁰¹King, p. 87.

¹⁰²H. V. Scarborough, "Treatment of Tuberculosis at the Iowa State Sanatorium," The Modern Hospital 2 (June 1914): 382.

physicians wanted to pay to people in the early stages of the disease, when treatment was presumed to be most effective and people most in need of their skills. The terminally ill presented no scientific challenges. It also accounts in part for the difficulty of staffing sanatoria -- they lacked the prestige increasingly enjoyed by general hospitals or medical schools where clinical and technological research generated rapid change in therapeutic approaches.

Like mental institutions, sanatoria "served a variety of purposes, some of which were inadvertently thrust upon them by a society seeking solutions to novel problems which grew, in part, out of rapid social and economic change."¹⁰³ It is clear that the problem for which sanatoria were posited as solutions was only in part a medical problem. First, most consumptives could have been equally well treated at home if the money spent on the construction of sanatoria had been spent on better housing and support services. Second, sanatoria didn't cure many people. Third, enough people never could have been isolated in sanatoria to stop the spread from person to person -- it would have been impossible to have had enough beds to institutionalize every indigent consumptive until death or cure occurred.¹⁰⁴

The true problem of the sick poor in cities, then as now, was only in part medical. We know that tuberculosis declined because

¹⁰³Ibid., p. 141.

¹⁰⁴In England, for example, only 2% of consumptives had been admitted to sanatoria in 1911. F.B. Smith, The Retreat of Tuberculosis 1850 - 1950 (London: Croom Helm, 1988), p. 130.

standards of living rose -- the problem of the sick poor is also a problem of housing, employment, general sanitation, and nutrition. It is complex and resistant to simple solutions. By spending inordinate amounts of time staging the disease of each patient before, during and after admission, and then devising rules and regulations for how patients should eat and rest, physicians convinced themselves that they were curing tuberculosis. Similarly, by spending large amounts of money on facilities to which the more bothersome and frightening patients could be sent, medical professionals, philanthropists and tax-payers deluded themselves into thinking that they treating the disease effectively. All this probably did make some people more comfortable, and may even have cured some. More than anything, however, sanatoria, merely by their existence, reduced anxiety and made everyone (including, probably, the patients in them) feel that something was being done, that the situation was (or soon would be) under control.

CHAPTER II

HARTFORD AND ITS POOR AND SICK

This chapter introduces Hartford between 1900 and 1910 and discusses how the needs of its sick poor were met. After a general description of the city, the focus narrows, first to a consideration of philanthropic and public provision for the poor,¹ then to support available at the almshouse and finally to medical care available at the City Hospital and Hartford Hospital. Discussion of the treatment of tuberculosis occurs in Chapter III.

Hartford was a diverse, growing city in the first decade of the twentieth century. Although there was migration from other parts of the United States, newcomers from abroad accounted for much of the population increase -- between 1900 and 1910, the city as a whole grew 24% while the foreign born increased 40%. A growing number of the new inhabitants looked and sounded different from other immigrant groups. Canadians, English, Irish and Scottish continued to arrive at a steady rate, but the number of non-English speaking people (Austrians, Poles, Rumanians, Hungarians, Russians, Italians and Greeks) almost trebled in the decade.²

¹I have used "poor" broadly throughout this paper; it should be understood to include the working poor as well as the utterly destitute, because a chronic debilitating disease such as tuberculosis could impoverish even skilled artisans and lower white collar workers. This was a not inconsiderable part of the terror of the disease.

² Information extrapolated from Ellsworth Grant and Marion H. Grant, The City of Hartford, 1784 - 1984 (Hartford: Connecticut Historical Society, 1986), tables on page 178. Numbers from countries listed grew by 280 per cent over the decade.

Immigrants were attracted by the employment available in a large number of industrial and service enterprises. The census counted 888 manufacturers in Hartford in 1900; the city directory for that year lists 23 hotels, 62 restaurants, and numerous white collar employers such as insurance companies, law offices and state bureaus.³

As early as the 1870s, when the state capital was moved from New Haven, Hartford's downtown section had begun to experience a modest boom in construction of handsome office and business buildings, some with residential quarters on upper floors. This continued into the new years of the twentieth century,⁴ and the city fathers were proud of the modernity surrounding them. Hartford was the first city in New England to be lit entirely by electric lights; sewers and water mains had been laid under the streets, the majority of which were paved; most buildings fronting them were of brick or stone. Trolleys or "street railroads," already present downtown, pushed deeper into the suburbs as the decade passed.⁵ There were also a growing number of places of

³Abstract of the Twelfth Census of the United States (Washington: Government Printing Office, 1902), table 175, p. 368. Geers Hartford City Directory, (Hartford: Hartford Printing Co., 1900), pp. 705 b, u, v. [hereafter noted as Hartford City Directory, 19xx]. The Hartford City Directory, 1901 lists 123 attorneys (p. 756 - 7).

⁴Gregory E. Andrews and David Ransom, Structures and Styles: Guided Tours of Hartford Architecture (Hartford: Connecticut Historical Society and The Connecticut Architecture Foundation, 1988), pp. 2 - 39.

⁵The electric lights were turned on June 23, 1890. Hartford City Directory, 1900 p. 706f. The Hartford City Directory, 1897 was the last to code streets to indicate the presence of electric

bucolic beauty -- by 1895 five major parks had been added to the forty year old Bushnell Park to create a green ring around the city.⁶

Despite such amenities, Hartford was an old city, and rapid population growth had not been accompanied by a commensurate increase in such fundamentals as decent housing in the parts of the city in which the poor congregated. As each wave of successful immigrants moved along trolley lines to ethnically defined neighborhoods to the north, south and west, some remained behind in the increasingly overcrowded east side which had been their first stop.⁷ Misery and disease flourished in an environment of overcrowded tenements and poverty.⁸

lighting, gas pipes, sewers and water mains; it indicates they were present for all streets in the center of the city. See also Hartford Board of Trade, Hartford, Connecticut (Hartford: Board of Trade, 1889) p. 152. The Atlas of the City of Hartford CT (Springfield MA: L.J. Richards & Co., 1896 and 1909) indicates building materials, presence of sewers, trolley lines, etc.

⁶Pope Park, Keney Park, Riverside Park, Goodwin Park, Colt Park. Elizabeth Park in West Hartford, also acquired at this time, was on a trolley line and easily accessible to Hartford people. John Alexopoulos, The Nineteenth Century Parks of Hartford: A Legacy to the Nation (Hartford: Hartford Architecture Conservancy, 1983), pp. 23 - 28.

⁷Robert Pawlowski, How The Other Half Lived (West Hartford: N.W. Catholic High School, 1973); telephone interview with Michael Persky of the Hartford Architecture Conservancy by author, January 30, 1991.

⁸Hartford's tenements were among the worst in the United States, and there were no laws controlling conditions in them other than general requirements for light and ventilation. See Robert DeForest and Lawrence Veiller, eds The Tenement House Problem (New York: The Macmillan Co., 1903), pp. 57, 155.

THE POOR: PUBLIC SUPPORT AND PRIVATE PHILANTHROPY

The city fathers felt some responsibility for the poor and had operated a residential facility first called a "town farm" and later an "almshouse" for the destitute homeless as early as 1811.⁹ "Families with infant children whom it is desirable to keep together under the care of their parents" could receive "outdoor relief"¹⁰ in the form of food, fuel and financial assistance for rent and transportation costs from the "keeper of the storeroom" at the almshouse.¹¹

Compassionate citizens realized that such aid was often both too little and too late, and a variety of organizations formed by Hartford's privileged had arisen by the 1890s. There were benevolent, religious and philanthropic groups interested in causes as varied as housing for single women, clean streets, parks and playgrounds, recreational programs for children, literacy (primarily for immigrants), training programs for employment for the poor (usually "housekeeping" courses for immigrant women to prepare them for domestic service) and many others. Members of some associations watched over the functioning of city departments and sat on

⁹Charles W. Burpee, History of Hartford County Connecticut (Hartford: S.J. Clarke Publishing Co., 1928), Vol I, p. 244.

¹⁰Board of Charity Commissioners Annual Report, (Hartford: Ward Printing Co., 1897), p. 6. This enabled families to remain together. If parents were homeless, their dependent children were sent to the city orphanage.

¹¹For a discussion of goods and services supplied see, for example, "Charity Department," Municipal Register of The City of Hartford (Hartford: Case, Lockwood, Brainard and Co., 1904), pp. 447 - 8

the boards of Parks, Police, Street and Charity Commissions. Hartford's comfortable and affluent families were well represented on the rosters of such clubs and organizations.¹²

Well meaning as members of these associations were, there was inconsistency and overlap both within and among the groups. By 1890 the situation had become so chaotic that representatives of charitable agencies formed an umbrella organization, the Charity Organization Society.¹³ After an investigation sponsored by the society, in 1896 public charity was placed in the hands of the members of a Board of Charity Commissioners,¹⁴ who were to

¹²See Barbara Donahue, Civic Club of Hartford (Hartford: Trinity College MA thesis, 1992), and Janet T. Murphy, The Union for Home Work: A Study of 19th Century Female Benevolent Societies (Hartford: Trinity College MA Thesis, 1988) for discussions of many of these organizations. The Donahue paper provides an extensive discussion of tenement reform cooperatively carried out by a number of benevolent societies. City Directories of the period offer listings of many clubs and associations whose titles suggest civic involvement. The following partial list is taken from the Hartford City Directory, 1901 (pp. 894 - 896): Charitable Society, Church Home, Civic Club, Friendly Visitors, Hartford Branch of the Children's Aid Society, Hebrew Benevolent Association, Larabee Fund [for the relief of "lame, maimed and deformed females"], Motherhood Club, Open Hearth [then as now, a shelter] Shelter for Women [later the YWCA], Union for Home Work, Widows Society, Womens Aid Society, YMCA. The Hartford City Directory, 1910 retains all these and adds a few: Consumptives Aid Society, German Aid Society, Hartford Settlement, Visiting Nurse Association.

¹³The Charity Organization Society movement was national in scope; what occurred in Hartford was typical of such efforts in many other cities. See Kenneth L. Kusmer, "The Functions of Organized Charity in the Progressive Era: Chicago as a Case Study" Journal of American History 40 (December 1973): 657-78.

¹⁴There were 6 commissioners, each of whom served a three year term. Two rotated on and two off each year. I have been unable to discover who appointed them -- perhaps they formed a self-sustaining board. Most served only one term, but 9 of the 22 men appointed between 1896 and 1910 stayed on -- six for two terms and

administer the almshouse and oversee the expenditure of all city funds paid to or expended for the poor. This change brought order and accountability to the city's disbursements and planning process for the almshouse and outdoor relief. Annual reports began to appear in 1897 which documented money spent, people served, staff activities and building repair and renovation.¹⁵

The Charity Organization Society intended that the private sector should function in an orderly manner as well. Voluntary organizations were to cooperate in their almsgiving by maintaining central records so that information could be shared and by allowing the Society to conduct "investigations" of petitioners to be sure they were qualified to receive aid.¹⁶ The agencies in question, however, did not always wish to be organized. They were jealous

three for three terms. See Board of Charity Commissioners Annual Reports, 1897 - 1911.

¹⁵These reports are remarkably detailed, and deserve close attention. They discuss building plans and renovations and give financial breakdowns of monies expended on salaries, administration, and food or supplies distributed to recipients both within and outside the almshouse. Those "out door poor" who received \$12 or more in aid in the year were listed by name and amount spent on them; those buried by the city were also named. Statistical breakdowns were made by nativity, occupation and age of almshouse inmates, and they too were named. People who had died at the almshouse or at the hospitals were recorded. For each hospital, patients whose care had cost the taxpayers more than \$12 in the year were enumerated along with the dollar amounts spent for each. The insane were named and statistically summarized in a similar manner. Orphan children were not identified but disposition of children to the various orphanages was summarized.

¹⁶Donahue, pp. 7 - 15 discusses this and lists some of the many benevolent clubs and societies involved. For an extended discussion of one of the first and most important of these, see the Murphy paper.

of their independence and reluctant to relinquish any control over their particular clients.

In 1901, the executive director of the COS found it necessary to reassure members that no "interference" in their operations was intended, that "centralized management" was not a goal, and that all that was sought was co-operation so that agencies did not "frustrate" each other's plans.¹⁷ Despite hesitations about the propriety of sharing information or having potential recipients investigated, most agencies participated in the program proposed by COS. The needy also seem to have recognized the effectiveness of the Society's clearing-house activities and began to apply directly to it for help. In 1901 there were 1,652 direct applications compared with 1,370 through provider agencies; by 1910 the figures were 3,773 and 1,871 respectively.¹⁸

The magnitude of the problem of poverty in Hartford is suggested by the fact that the Charity Organization Society maintained files on 5,919 families in 1901.¹⁹ This statistic is

¹⁷Charity Organization Society Annual Report, 1901 (Hartford: W. H. Barnard, 1901), pp. 5 - 6. I could locate only annual reports for 1901, 1908 and 1910.

¹⁸1901 figures from Charity Organization Society Annual Report, 1901, pp. 6, 8; those for 1910 from COS Annual Report, 1910, p. 6.

¹⁹COS Annual Report, 1901, p. 7. Incredibly, this could represent as many as 25,000 individuals -- and the population of Hartford at this time was around 100,000. Almshouse outdoor relief statistics for 1904 indicate that the 133 families receiving aid consisted of 623 persons. ["Charity Department," Municipal Register, City of Hartford 1904, p. 446] My calculations indicate that this is an average of 4.7 individuals per family; if the COS families were as large, it works out to 27,819 people. Perhaps families in the COS files were much smaller, or the city's

from the early period, when agencies were reluctant to share information about applicants, and thus may be an under-representation of the extent of need in the city. It is no surprise that even to begin to meet such a high level of distress required the efforts of the city government and a number of private charitable agencies as well. Although many recipients of charitable assistance were probably experiencing temporary difficulty and passed through their hard times relatively quickly, some were dependent for years or even lifetimes. The problems presented by the sick, disabled, elderly, orphaned and homeless required more permanent (and costly) solutions. Throughout the nineteenth century a number of institutions for those purposes had been established in the city.

Residential institutions had begun to appear early in the nineteenth century, and by 1900 there were two hospitals, Hartford Hospital (1854) and St. Francis Hospital (1897), a "Dispensary" or out-patient clinic, three homes for the aged/widowed, three orphanages, a home/school for the blind and another for the deaf, a "retreat" for the insane, and an almshouse.²⁰ Virtually all

provision of outdoor relief selected large families over individuals -- the presence of dependent children may have predisposed officials to grant aid more readily. It is also possible that the COS retained records of families to whom assistance had been denied, thus artificially increasing the number. On the other hand, the mere application for help indicates a felt need on the part of the suppliant. In any case, the COS figure may be taken as an indication that the needy population was in fact quite large.

²⁰Hartford City Directory, 1900. See also: Burpee, Volume II pp. 691 - 4; William F. Henney, "Modern Factors in Municipal Progress" Connecticut Magazine 9 (1905): 825 - 7, 836 - 7; Robert

these had been founded by and were operated with money donated by the citizens of the city. Municipal and state funds sometimes subsidized care or maintenance of the inmates, but only the almshouse and one orphanage in the above list were directly financed by the city's taxpayers.

THE POOR: THE ALMSHOUSE

In the last quarter of the nineteenth century the city constructed a new almshouse on Holcombe Street, on the north edge of town, to provide a place for the indigent homeless.²¹ The average daily census of this facility in 1900 was 226 people.²² Accommodations consisted of large dormitories with separate facilities for men, women and children; there were flush toilets, and hot water ran to the porcelain bath tubs and the showers.²³

A. Woods and Albert J. Kennedy, eds Handbook of Settlements (New York: Arno Press, 1970) (reprint of 1911 edition) pp. 27 - 8.

²¹Burpee, Volume I p. 244.

²²Report of the Board of Charity Commissioners, 1900 p. 6. On the day the census was taken, June 2, the enumerator found 92 men, 76 women and eight children in residence at the Almshouse. We can assume this to be one of the lowest populations of the year, since those able to work at seasonal agricultural jobs would have left. 1900 Manuscript Census, reel 137, enumeration district 539, sheets 1A - 2B.

²³Report of the Board of Charity Commissioners, 1898, p. 11 - 12 and 1899, p. 6. The commission replaced separate rooms with dormitories in these years, and they were large indeed. The 1898 report describes a male dormitory of 102 x 32 feet to hold 55 beds; the female dormitory was of similar size but no bed numbers were specified. In 1899 a second male dormitory, 95 x 48 feet for 74 beds, was added. The children's dormitory (also described in 1899) was 42 x 28 feet, but no number of beds is given. All dormitories were called "light and airy," and the management felt they were a "great improvement on the room system" because they promoted "discipline and cleanliness" and (probably more importantly) provided space for more beds. (1898, p. 12)

Yet the almshouse was as much a jail as a refuge for its inmates: The Hartford Courant noted in 1903 that they were "allowed out once a month for visiting," a decrease from the former practice of twice a month because they had "returned from the city in poor condition."²⁴

Idleness was not encouraged or tolerated in the almshouse. Residents provided labor for routine maintenance as well as for most new construction and renovations. Men chopped wood, painted, dug a sewer line, built an ice house, and acted as masons and carpenters. Women did the laundry and sewed dresses for themselves and the children and shirts, overalls and "jumpers" for the men. Nevertheless, the Charity Commissioners noted in 1898 that they were "still wrestling with the problem" of "provid[ing] systematic and constant employment for all the inmates at all seasons of the year suited to their conditions and capacities."²⁵

THE SICK POOR: SOURCES OF CARE

When indigent people were ill, they could receive care at a dispensary (and doubtless some physicians treated the poor either for a reduced or no fee in their private offices) or consult a city physician who practiced out of the almshouse. The city and the hospitals themselves subsidized hospitalization when patients were

²⁴Hartford Courant January 3, 1900, p. 5.

²⁵Quote from Charity Commissioners Annual Report, 1898, 12. Other information from the annual reports of this board in the years 1898 and 1899 which contain most information about actual living conditions of the inmates because the Board was in the process of reorganizing both the physical plant and the administration of the almshouse. After 1900, little is said on the matter.

destitute. Private charity groups do not seem to have been of much help to people who had difficulty paying medical bills. The Charity Organization Society's annual reports probably do not summarize aid given by all philanthropic and religious sources, but they offer the only information available about how private monies were dispensed. Their tables show that non-public resources used by the Society to help with medical and hospital costs came from relatives, friends, churches and Sunday schools.²⁶ Voluntary agencies were more interested in the wider social aspects of disease prevention and control (clean streets, parks, nutrition) and were largely non-participants in the struggle with illness once it had reached the stage where treatment was necessary.

Some physicians in Hartford tried to regularize and organize their free care by establishing what would today be known as an outpatient clinic. Their first effort to establish what they called "The Hartford Dispensary," was undertaken in 1871 and failed for want of patients, but their second attempt, in 1884, was successful. Staffed by volunteer physicians recruited from among members of the Hartford Medical Society, assisted by the "young ladies of the Junior League [who] gave their services as attendants," the dispensary was on Prospect Street. It is difficult to know whether this is the same "dispensary" at which the city

²⁶Charity Organization Society Annual Report, 1901, p. 14 - 15; 1910, p. 19. The table "What Was Done For The Applicants" lists sources of relief by name and then the kinds of help obtained after each source. "Board at hospital" or "medical treatment" occur in lists including "coal," "rent," "stove repairs" and the like -- and for some funding sources there is no indication of how the money was spent.

physician called, or if there was also a dispensary at the almshouse. The latter seems more likely, since those writing the annual report for the Hartford Dispensary noted with pride that it was a "purely private" charity, receiving no city funding.²⁷

The almshouse was a place to which people went both for outpatient care and for examinations to determine whether they qualified for city subsidized hospitalization elsewhere. Hiring a medical doctor to work directly for the city appears to have been part of the reorganization of public aid instituted by the Board of Charity Commissioners, for mention of the position appears first in 1898. The city physician resided at the almshouse, where he also received board and a horse and carriage.²⁸ Although his duties were not specified, they can be inferred from later annual reports of the Board of Charity Commissioners, which always gave statistical information about his work. In 1903, for example, the report listed 678 house visits, 3,228 treatments performed at the almshouse, 1,374 calls at the dispensary, 899 cases examined for admission to the hospital (see below), 195 cases examined for admission to the almshouse (of which 129 were approved), 82 cases examined for insanity (52 admitted) for a total of 6,716 treatments

²⁷Burpee, Volume II, p. 691 - 2. The Hartford Dispensary Annual Report, 1916 (no publication data listed), p. 3. This is the only annual report for the Dispensary I have been able to locate. In that year, 8806 patients were seen (p. 22).

²⁸Board of Charity Commissioners Annual Report 1898, p. 7.

and examinations. Medicines were made available to the poor at the almshouse.²⁹

Patients whose bills were to be paid by the city were not admitted to a hospital without approval by the city physician. This was granted more often than not; in 1902 - 3, for example, 899 cases were examined for admission to the hospital and 652 (72%) were approved.³⁰ Until the city formally added medical units to the almshouse in 1906, 40 - 45 percent of funds appropriated for care of the city's poor were spent upon institutional care for the sick or insane.³¹

²⁹"Board of Charity Commissioners," Municipal Register, City of Hartford, 1903, p. 585, 599. This report gives the physician's annual salary as \$1,000.

³⁰"Charity Commissioners Annual Report," Municipal Register, City of Hartford, 1903, p. 599. The city physician also examined "cases of insanity" for referral to institutional care and the approval rate was a bit lower -- 52 of 82 (63%). The approval rate seems to have increased as the decade progressed -- in 1908, the city physician approved 85% of those he examined for hospitalization. (Report of Board of Charity Commissioners, 1908 p. 13). Whether this is because of better pre-screening with the result that he was seeing only the really ill or whether it represents the availability of more beds (the City Hospital was also in operation by this time), is unclear.

³¹Costs were carefully detailed, though sometimes not broken into categories useful to the modern investigator. Thus, money spent for the "insane and imbecile" is not separated from that expended for the physically ill. The 40 - 45% figure is derived from "Charity Commissioners Annual Report", Municipal Register, City of Hartford, 1903, pp 584, 600 (\$36,905.34 of appropriation of \$89,000 or 41%); "Charity Commissioners Annual Report," Municipal Register, City of Hartford, 1904, pp. 445, 463 (\$39,142.94 of appropriation of \$91,000 or 43%). It decreased only marginally when the almshouse included inpatient facilities -- see Annual Report of the Board of Charity Commissioners, 1908, p. 5 (\$39,207.61 of appropriation of \$109,000 or 36%).

The almshouse provided minimal inpatient care for residents in the years before 1905, and after that date began to function as a municipal hospital. As early as 1899 there was a ward for (male) inmates with tuberculosis and another for the "detention of mild cases of insanity." Over the next few years, space was rearranged so there were separate areas for sick men, women and children (considerably smaller than the dormitories for sleeping), and least four "strong rooms" "to be used for the confinement of violent cases of insanity and for violation of rules". During this early period there was no nursing or medical staff on site; nursing sick fellow inmates was probably among the housekeeping chores assigned to female residents.³²

THE SICK POOR AND THE CITY HOSPITAL

In the first years of the new century, charity commissioners became concerned about the increase in numbers of sick inmates, especially since many of them had tuberculosis. As noted above, male residents with tuberculosis had been assigned to beds separate from the general dormitories since the end of the nineteenth century, but the increasing number of female consumptives now

³²Board of Charity Commissioners Annual Report, 1899, p. 6; 1906, p. 5. Wards for men and children were already present in 1897 but one for women was not added until 1905. Before 1906, the jobs of the matron and her staff were to oversee the residential population. When nurses were added to the payroll, the head nurse was paid \$540, the matron \$355, and regular nurses approximately \$273 per year. (Board of Charity Commissioners Annual Report, 1906, pp. 31 - 34.) This suggests that the head nurse's position carried more authority and responsibility. When the city hospital was an established entity, nurse and matron worked in separate parts of the building and had distinct functions.

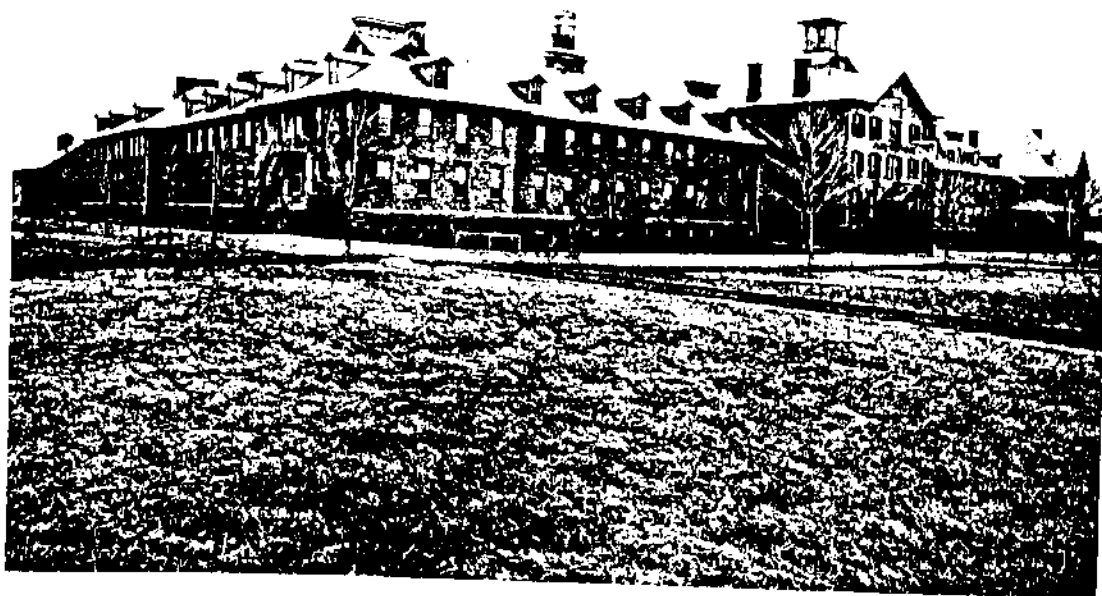


Figure 2: City Hospital and Almshouse

The first time it appeared as an illustration in the "Report of the Charity Department," Municipal Register, City of Hartford (Hartford: Case, Lockwood and Brainard, 1913), facing page 729.

became a worry.³³ As will be related in detail in Chapter III, Hartford Hospital had been the destination for consumptives requiring hospitalization, but in 1903-04 it stopped admitting tuberculosis patients. The hospital was experiencing financial difficulties and requested that the city increase its payment for the care of indigent patients (regardless of diagnosis) from \$4.00 or \$5.00³⁴ per week to \$8.00. After a long discussion, the aldermen decided to pay the requested amount until they could find another solution, and the solution they preferred was to add space to the almshouse, call the new area the city hospital, and care for the indigent sick there.³⁵

Additions to the almshouse, including a ward for female consumptives, were made in 1904-05, and 1905-06 was the first full year of operation of the section of the almshouse now known as the city hospital. [An image of the almshouse/hospital is reproduced as figure 2, opposite.] City-subsidized admissions to other hospitals began to decrease. In 1904-05, the city paid for the

³³Burpee, Vol II, p. 695.

³⁴The amount depends upon the source. It is given as \$4.00 in the discussion in the city's Common Council Board [Journal of Common Council Board, 1903 - 04 (Hartford: City Printing Co., 1903) p. 833] and as \$5.00 per week in the Hospital's data [Hartford Hospital Annual Report, (Hartford: Case, Lockwood, 1904), p. 13.] It is not always clear in the hospital's materials exactly which kind of patient fee is being discussed -- for example, paying patients were charged \$7.00 per week [*ibid*], the state paid \$6.00 per week for old soldiers and the U.S. Customs House paid \$7.00 per week for sailors. [Hartford Hospital Executive Committee Minutes, December 29, 1903, p. 6 - 7. In any event, it is clear that the hospital charged the city considerably less than other payment sources.

³⁵Journal of the Common Council Board, 1903, pp. 833 - 843.

care of 380 people at Hartford Hospital. In 1908, only 127 were referred there.³⁶

The new city hospital, however, was not popular among the people of Hartford. The hospital wards of the almshouse contained 111 beds, but during the first year the average daily census was only 56 patients.³⁷ People did not want to be admitted to a hospital connected to the almshouse even though the Charity Commissioners had tried to keep the two as separate as possible.³⁸

A year after the city hospital opened, Hartford Hospital had recovered from its financial difficulties. It reopened its tuberculosis facilities and decreased its charges to the city to \$7.00 per week per patient for those with tuberculosis or other contagious diseases and \$5.00 per week per patient for all others.³⁹ The Board of Charity Commissioners thought it best to "get rid of all tubercular patients at the Almshouse, and they were

³⁶Annual Report, Board of Charity Commissioners, 1905, p. 23 - 27; Annual Report, Board of Charity Commissioners, 1908, p. 25 - 26. These reports list names of individuals for whom the city paid \$12.00 or more at the named hospital in the past year. This is the only source of information about hospital use by city-supported patients; unfortunately for the researcher, there is no demographic information given for the people listed except their names and the dollar amount spent upon them.

³⁷Journal of the Common Council Board, 1906-07, p. 1029.

³⁸Their zeal to separate the two facilities, however, did not extend to providing separate entrances for them. A second doorway would have cost \$300, and the committee "[did] not consider such action worthy of the expense." See Journal of the Common Council Board, 1906 - 7, p. 1035.

³⁹Hartford Hospital Executive Committee Minutes, March 21, 1907, p. 102.

accordingly transferred to the Hartford Hospital Tubercular Annex about September 1, 1905, and these wards [i.e. those now vacated at the city hospital] were put in use for Hospital cases."⁴⁰

A controversy then arose among the city councilmen over whether or not to keep the city hospital section of almshouse open. It was difficult for the councilmen to compute daily cost per patient at the city hospital because it was unclear which fixed costs (heat, repairs, insurance, etc) should be charged to the hospital and which to the almshouse. The committee reporting to the Common Council Board thought it was probably about \$5.00 per week per patient excluding fixed expenses. Patients requiring acute care or special treatments had to be sent to other hospitals; the city hospital had no x-ray machine, could not accommodate contagious or tubercular cases, and lacked facilities for special problems such as eye cases. Nevertheless, a majority of an investigating committee endorsed a report stating that on the whole the economics of treating the indigent ill in a city hospital attached to the almshouse were favorable.⁴¹

A considerable difficulty was presented by what the common council delicately called "sentiment." The city hospital was not a place to which people were willing to be admitted. A majority of the committee reporting upon the problem insisted that no stigma was or should be attached to admission to the city hospital. A

⁴⁰Board of Charity Commissioners Annual Report, 1906, p. 5.

⁴¹Journal of the Common Council Board, 1906 - 07, pp.1028 - 1033.

vocal minority felt that, not only had the costs been underestimated, but also there was great resistance among the people to being admitted to a hospital located on the edge of the city in the almshouse. This group wished to close the wards at the almshouse except for care of its chronically ill inmates.⁴²

Care of the poor of the city was a matter of heated discussion among physicians as well. The minutes of the Hartford Medical Society for February 5, 1906 note that a subcommittee had a "long and stormy session and needed the assistance of the members [of the society] on the question of the care of the town poor; that as they knew of no specific case whatever of any neglect or improper care on the part of the town physician, they would like any one knowing of any such instance to report same to the committee in detail."⁴³

At the next meeting, the topic of which was "The Care and Disposal of the Sick Poor of Hartford," a physician complained that the poor did not know how to call the town physician at "odd hours." The problem, he continued, was not with the town physician, but with the policies of the Board of Charities, which, he thought, "purposely made it difficult [to contact the town physician] in order to lessen the number of calls."

The ensuing discussion was as much about the finances of a hospital at the almshouse as about the quality of care received by the patients. Note was taken of how unwilling the poor were to be

⁴²ibid., pp. 1033 - 41.

⁴³Hartford Medical Society Minutes, Vol. 19 (1906-7), p. 16.

treated in the almshouse hospital (with an example of a "boy with appendicitis who begged not to be taken to the almshouse") and of how the poor sometimes found friends to pay for them at St. Francis or Hartford Hospitals but ended up being "thrown upon the charity of the hospital." Several speakers disputed the cost estimates made for the almshouse hospital, asserting that it would burden the taxpayers less if the sick poor were treated at one of Hartford's other hospitals at city expense. Eventually the members of the society agreed that the "infirmary at the almshouse should be used only for the care of the sick inmates of the almshouse, and for such chronic cases as are permanent city charges." As one remarked, there was "but half a hospital at the almshouse."⁴⁴

The city hospital, however, did not close. After a long discussion, the City Councilmen reached a compromise whereby "any sick person, temporarily unable to meet the expense of his care, may choose the hospital to which he shall be sent, with the understanding that he will repay the expense as soon as may be after his recovery." The Charity Commissioners were to be "relied on to make use of the [city hospital] in a manner worthy of the City's reputation for kindness and humanity."⁴⁵ There is no indication that this policy was ever implemented,⁴⁶ and the

⁴⁴Hartford Medical Society Minutes, Volume 19, pp. 25, 41-46, 48.

⁴⁵"Mayor's Message" Municipal Register, City of Hartford, 1907, pp. 10 - 11.

⁴⁶The hospital at the almshouse remained in a kind of institutional limbo, staffed by the city physician, his assistant and a handful of nurses, until the early 1920s. After a study by the

hospital at the almshouse gradually received more staff, although the average daily census continued to hover between 50 and 60 throughout the period under discussion. By 1908 there was a head nurse with ten nurses under her,⁴⁷ and by 1910 the city physician was also known as the "Surgeon in Chief" and had been joined by a "Visiting, Medical and Surgical Staff" consisting of four other physicians and an intern.⁴⁸

THE SICK POOR AND HARTFORD HOSPITAL

Although St. Francis Hospital had become the second inpatient facility in the city in 1897, Hartford Hospital remained the primary source of care for indigent patients. St. Francis refused tubercular, syphilitic, "and a number of other cases ... for the very good reason that their nurses are sisters, and they don't think they ought to compel those sisters, who work for nothing, to

Board of Charity Commissioners in 1921 a new system of rotating physicians was adopted, and a coalition of some 62 doctors from St. Francis and Hartford Hospitals staffed it. At some point between then and the 1960s, it was renamed McCook Hospital and the almshouse building was replaced by a brick box. In the 1950s, it was absorbed by the University of Connecticut for its medical school and moved out of the city to a new campus in Farmington in the 1960s. The original site on Holcombe Avenue is now city administrative offices. Information about the 1921 reorganization may be found in a folder, "Hartford Connecticut Municipal Hospital: History of the Formation of the Rotating Staff" at the Hartford Medical Society. The whereabouts of the records of the almshouse and McCook Hospital is unknown.

⁴⁷Board of Charity Commissioners Annual Report, 1908, p. 33. There was also a hospital steward. Costs for hospital and almshouse, however, were not separated.

⁴⁸Board of Charity Commissioners Annual Report, 1911, p. 3.

take care of disgusting diseases."⁴⁹ Such "disgusting diseases" were especially likely to be the lot of the poor, so the locus of their care continued to be Hartford Hospital. That institution's operating expenses were met by a biannual state appropriation of \$10,000⁵⁰, endowment, philanthropic giving, benefits given by civic groups, and patient fees.⁵¹

Charges to the city did not cover the cost of treating indigent patients, though the amount of the loss varied according the level of care required. Cost to the hospital for the contagious disease ward, for example, was over \$16.00 per week per patient, but the city paid only \$3.00.⁵² General ward patients cost the hospital \$1.85 per day (or \$12.95 per week), but the

⁴⁹Journal of Common Council Board, 1903, p. 840. Hartford Hospital consistently received around five times as many patients as St. Francis. The 1905 Charity Commissioners Annual Report's lists of people whose hospital board was \$12.00 or more in the year shows that Hartford Hospital treated 379 patients, St. Francis 72 [pp. 23, 27-8]. In 1908 the figures were 127 for Hartford Hospital, 21 for St. Francis [pp. 25-27.]

⁵⁰See Public Acts, State of Connecticut (Hartford: State of Connecticut, 1901, 1903, etc.) for 1901, p. 1405 - 6; for 1903, p. 242. This was not unusual -- the primary hospital in most large cities (Bridgeport, Danbury, Norwalk, New London, Meriden, etc) received the same amount.

⁵¹Endowed beds were a phenomenon unfamiliar today. A church, organization or individual, in return for a sum of money had the right to nominate a patient to occupy a bed and receive care at no charge. Exactly how this system worked is unclear to me, but it was a common way to provide treatment to people who could not afford to pay for all or part of their stay.

⁵²Journal of the Common Council Board, 1903, p. 836.

charge to the city was \$7.00 per week.⁵³ The fees for "paying patients" were only \$8.00 per week, and even this could be reduced to \$7.00 "in the cases of deserving patients who ... very properly could not and should not be expected to apply to the city for relief."⁵⁴ The shortfall was met from the hospital's endowment and philanthropic gifts.

Despite charitable contributions, the deficit at Hartford Hospital was chronic and slowly growing. When it reached alarming proportions in 1902, the Board of Directors authorized an appeal for help to the citizens of Hartford, and within three months the \$74,888 short-fall was covered.⁵⁵ This scare forced the Board to assume direct responsibility for day-to-day operations. Administrative practices and policies were examined and changed where necessary, and in general the men running the hospital thought, perhaps for the first time, about the shape they wished the hospital to take in the future. One of their decisions was to try to attract private patients who could pay the full cost (and more)

⁵³For daily cost per patient, see Hartford Hospital Annual Report, 1908, p. 47; for fee charged to city, see Hartford Hospital Executive Committee Minutes (March 21, 1907), p. 102.

⁵⁴Such income loss was charged to the income from the "Keney fund" (an endowment) or the "income from the general fund of the hospital" or to the state appropriation. No information is given about how such patients were selected or how they differed from those who could be expected to receive aid from the city. Hartford Hospital Annual Report, 1904, p. 13.

⁵⁵Hartford Hospital Board of Director Minutes, January 30 and March 29, 1902, pp. 36, 39.

of their care.⁵⁶ Although there was no intention of ceasing to care for the kinds of patients who had been the hospital's constituency for the past fifty years and who, the board members clearly understood, would continue to compose the bulk of their clients, making the hospital attractive to middle class paying patients became a strong secondary objective. Its impact upon patients with tuberculosis was of major importance in determining where and what kind of care they would receive, and is discussed fully in Chapter III.

CONCLUSION

Although a prosperous and growing city, Hartford at the beginning of the twentieth century was only in the first stages of developing a coherent plan for caring for its less fortunate citizens. Private philanthropy and initiatives had dominated the provision of aid to the poor throughout the nineteenth century, and city government was slow and reluctant to assume responsibility for the poor, especially if they were also ill. Councilmen hesitated to undertake funding and managing a municipal hospital, and physicians at Hartford Hospital were unwilling to lose the

⁵⁶See Hartford Hospital Executive Committee Minutes, 1903 and 1904. The executive committee undertook a myriad of large and small tasks such as investigating patient complaints, introducing a new accounting system, hiring and firing personnel, reorganizing space to make room for laboratories, promulgating rules for patient visitors, inspecting the bathrooms, requiring that house staff attend 8:00 a.m. breakfast, disciplining student nurses, recommending a new and improved telephone system -- the list goes on and on. As a new administrative staff was put in place, the committee gradually withdrew its direct involvement. The Executive Committee Minutes of July 8 1904 (p. 37) record a vote to accept patients who wished private rooms and special nursing for \$35.00 per week.

reimbursements paid by the city for indigent inpatients even though fees did not cover the actual cost of providing care. A fully operative city hospital would mean empty beds at Hartford Hospital, a prospect the latter's directors must have viewed with alarm. However, as hospitalization became increasingly accepted by middle class patients who could pay in full for the services they received, the directors began to entertain the notion that the future of their institution lay in attracting this new constituency.

The reluctance by all institutions to provide for the sick poor showed up most dramatically in the case of destitute consumptives. The city sent them to Hartford Hospital whenever possible. As we will see below, Hartford Hospital first tried to transfer all of them to the sanatorium it built on the edge of the city. When that failed, hospital directors admitted the very ill and terminal cases to special wards at the main hospital and those in the earlier stages of the disease to the sanatorium. This solution was problematic and probably would not have been successful; fortunately, a tuberculosis commission recommended to the State of Connecticut that state sanatoria should be built and should be open to all tubercular patients, regardless of stage of disease or ability to pay. Both the city and Hartford Hospital greeted this news with relief and hastened to transfer consumptives to the state sanatoria as soon as they began to open in 1910.

The poor themselves probably tried to avoid entanglements with institutional medicine. When admission was inevitable, they may have preferred Hartford Hospital over a city hospital located in

the almshouse. As will be discussed below, when a representative of the working class became a Tuberculosis Commissioner, he was a strong proponent of a state sanatorium system. Workingmen were not destitute, although tuberculosis in the wage earner could reduce a family to that condition quickly, and any institution smacking of the almshouse was doubtless unacceptable to them. If they could not join together and pay for their own in Hartford Hospital, as they briefly tried to do, a state institution seemed a better choice.

CHAPTER III

TUBERCULOSIS IN HARTFORD

In Connecticut, tuberculosis mortality continued a half-century trend of decline in the first decade of the twentieth century.¹ In Hartford, however, this was not apparent -- consumption fluctuated between the second and fifth leading cause of death between 1896 and 1910, with no discernable pattern.² Regardless of improvements elsewhere, for Hartford, tuberculosis mortality remained a significant problem. In 1901, for example, eleven per cent of all deaths in the city and 14 percent of deaths at Hartford Hospital were from tuberculosis.³ It was a disease of the poor, and the poor were concentrated in the city. There are no data correlating tuberculosis rates and income levels for the period in Hartford, but by the middle of the decade when it had become a reportable disease, the health department listed the number of tuberculosis cases by ward. The case counts in wards containing tenement districts were always much higher than other parts of the

¹TB death rate per 10,000 in Connecticut decreased from 26.7 in 1849 to 20.6 in 1890 to 13.4 in 1908 [State Board of Health Annual Report, 1908 (Hartford: State of Connecticut, 1909), p. 37.]

²"Health Department," Municipal Register, City of Hartford, (Hartford: Case, Lockwood Brainard, 1912), Table VII, p. 516. It was the second leading cause of death in 1897, 1901, 1904, 1905, 1909 and the fifth cause of death in 1902, 1903, 1908.

³Hartford Hospital Annual Report, 1901, p. 42; "Board of Health Commissioners," Municipal Register, City of Hartford 1901, p. 343, 348.

city, a finding which only confirmed what city authorities already knew -- the sickest were the poorest.⁴

The city took basic public health measures but does not seem to have pursued them with much vigor. In 1904 the Health Department required physicians to report cases of tuberculosis, but compliance was very slow in coming, and it was not until 1909 that the number of reported cases exceeded the number of deaths.⁵ The 1904 actions taken by the Board of Health to limit the spread of the disease also included an anti-spitting law, provisions to disinfect dwellings in which there had been a tuberculosis death, free examination of sputum submitted by physicians, and "literature about how [patients can] protect themselves and their neighbors against infection."⁶ By 1910 the number of sputum samples had risen to 153 (of which 36 were positive), and the bacteriologist complained that his laboratory was being used by the city's

⁴The reporting was not a case rate (cases per thousand, for example), but raw case numbers. Thus, a more populated part of the city was certain to have higher numbers of cases whether or not the rate was also higher, and the tenement districts were certainly densely populated. The actual numbers, then, are meaningless for modern statistical methods.

⁵"Health Commissioners Report," Municipal Register, City of Hartford, 1909, p. 571.

⁶For the reporting requirement, see "Health Department," Municipal Register, City of Hartford, 1904, p. 406. In 1906 there were only 73 reported cases but 173 tuberculosis deaths, and the report comments that "something must be radically wrong" with the reporting mechanism [Municipal Register, City of Hartford, 1906, p. 396]. In 1909 there were 128 cases and 119 deaths reported [Municipal Register, City of Hartford, 1909, p. 571]. It was made a reportable disease at the state level in 1909, just before the first public sanatorium was built. [see Public Acts (Hartford: State of Connecticut, 1909), Chapter 79, pp. 1010-12.]

physicians to save cost of the doing the examination themselves.⁷ On the evidence of its annual reports, the Board of Health was not aggressively involved in the anti-tuberculosis campaign.

Several voluntary organizations dedicated to the disease were formed before 1910, although they too seem not to have been very active. In 1906, the Executive Committee of Hartford Hospital directed two of its members to attend a meeting called by Mayor Henney "to organize a permanent anti-tuberculosis society."⁸ The city directory for the same year listed members of the board of a "Consumptives Aid Society" which included the Mayor, three Hartford Hospital board members and fourteen other physicians and businessmen.⁹ The National Society for the Study and Prevention of Tuberculosis (NASPTB) recruited representatives from each state. In 1908, the first year in which names were given, the Connecticut contingent included ten Hartford residents (of which three were also on the Consumptives Aid Society board).¹⁰ Unfortunately, there is no information about the activities of any of these organizations. It seems possible that Mayor Henney's "anti-tuberculosis society" might have been the same as the Consumptives

⁷"Health Department Report," Municipal Register, City of Hartford, 1910, p. 501.

⁸Hartford Hospital Board of Directors Minutes, November 14, 1905, p. 81.

⁹Geer's Hartford City Directory (Hartford: The Hartford Printing Company, 1906), p. 952.

¹⁰Transactions of the Fourth Annual Meeting of the National Association for the Study and Prevention of Tuberculosis, (Philadelphia: William Fell Co., 1908), p. 317.

Aid Society. Hartford Hospital records do not indicate that the Consumptives Aid Society ever assisted with payment of hospital bills, and the representatives sent to Mayor Henney's meeting did not report back. Vigorous anti-tuberculosis campaigns were waged in some cities before 1910, but Hartford was not among them.¹¹ Hartford's citizens and physicians were more interested in the sanatorium that was to be built on the edge of town.

After introducing an immigrant family ravaged by tuberculosis to illustrate both the individual tragedies the disease caused and the magnitude of the problem faced by medical authorities, this chapter describes the relationship between Hartford Hospital and its sanatorium, Wildwood, in the years between its opening in 1902 and the opening of the first state sanatorium, Cedarcrest, in 1910. Hartford Hospital's first priority in these years was making the transition from a nineteenth century custodial care facility to a modern, acute care, technologically sophisticated institution that could attract middle class as well as indigent patients. Hampered by financial difficulties, the hospital was never able to invest sufficient dollars or personnel in its sanatorium to ensure its success. Thus, the coming of the state system of sanatoria was welcomed by the hospital administration, for made it possible to close wards for chronic, advanced stage consumptives and refer indigent patients to the state facility.

¹¹See footnote 24, Chapter I, for discussion of and references for the NASPTB and the anti-TB public health campaign.

TUBERCULOSIS: THE BARBELLA FAMILY

The Barbella family represents the experience of many of Hartford's immigrant poor: Five of the six Barbellas died of tuberculosis and the sixth died in the almshouse after an eleven year residence there.¹² Unskilled and tubercular, members of the family struggled but failed to climb out of impoverishment into a self-supporting working class status. They were unusual only in that they left a bureaucratic paper trail for the researcher to follow eighty years later.

Italian immigrants Cono and Francesca Barbella had at least three children born in Hartford at two year intervals between 1888 and 1892. Francesca died of consumption at the age of 36, in 1894. Poignantly and not uncommonly, the immediate cause of death was listed as "exhaustion". She died at home, on Charles Street in the tenement district, and Cono continued to live in the neighborhood through the 1890s. He was listed variously as a "peddler" and "laborer" in the city directory in those years. In 1900 all three children (ages 12, 10, and 8) were in the Hartford Orphan Asylum; at the same time, Rose Barbella, age 66, was an inmate at the almshouse,¹³ where she was to remain until her death in 1911.¹⁴

¹²Documenting the lives of the very poor is difficult, as they are listed in city directories only intermittently if at all and tend not to use services which leave a bureaucratic paper trail. The story of the Barbellas is reconstructed from their census entries, death certificates, and city directory listings.

¹³These were the only Barbellas in the city directory or the census. Cono was clearly the father of the children; and the mother of all children is listed as Francesca. Rosa's relationship to them is guesswork. See 1900 Manuscript Census, reel 136, enumeration district 539, sheet 2; e.d. 185, sheets 18 and 19.

Could she have been Cono's mother, imported to care for the children after their mother's death? The family evidently broke up around 1900 -- perhaps Rose became too old or too ill to help maintain the home, or Cono resumed his peddling after the children were old enough to place in the orphanage.¹⁵

Tuberculosis appeared again among the Barbellas soon after the turn of the century. The oldest son, Joseph, died of the disease at Hartford Hospital at the age of 16, in 1904. His death certificate gave a Front Street address as his home, so the family had not left the district in which they had lived at the beginning of their time in Hartford. Four years later, in 1908, sixteen year old Mary (whose occupation was given as "laundress") died at the same hospital, also of tuberculosis. The charity commissioners paid the hospital \$113.14 for her care,¹⁶ indicating a fairly long hospitalization (at \$8.00 per week, it works out to around 14 weeks). Cono died two weeks after his daughter in the same ward of the hospital, of the same disease. The charity commissioners did not report paying for his hospital stay, indicating either that he had the means to pay for himself or, more probably, that he

¹⁴The Board of Charity Commissioners listed all almshouse "inmates" in their annual reports, and Rose appeared every year from 1900 to 1911. Her death certificate indicates that she died of uremia. She was thus the only family member not to die of tuberculosis.

¹⁵It is significant that the 1900 census was taken in June. Cono could have gone off on a summer selling trip, leaving his mother and children to be cared for by the city while he was away. This would save rent. Parents could leave children in the city orphanage temporarily and reclaim them later.

¹⁶Report of the Board of Charity Commissioners, 1909, p. 25.

entered the hospital only to die and was not there long enough to run up a bill of more than \$12.00. (The Charity Commission published names only of those for whom it had paid this much or more.) John, the middle child and last surviving Barbella, lived long enough to acquire a skilled trade. When he died of tuberculosis at the age of 24 in 1915 in Newington (probably at Cedarcrest, the new state sanatorium for Hartford County), he was listed as a blacksmith. Thus an entire immigrant family came and vanished, leaving only a faint trace in the record. It must have been that way for many: living in crowded, unsanitary tenements, working at hard and unskilled laboring jobs, dispersing the family when financial need was overwhelming, and eventually losing the struggle. It was this kind of family that presented formidable challenges to officials concerned with management of tuberculosis.

TUBERCULOSIS AND HARTFORD HOSPITAL

Care of the tubercular poor was not something willingly or eagerly undertaken by any agency or institution in Hartford at the beginning of the twentieth century. St. Francis frankly refused to admit them. (See above, Chapter II.) The almshouse wished to make no provision for them, though officials had been forced to reserve some spaces in a separate part of the building for consumptive inmates. Hartford Hospital had since its founding assumed responsibility for institutionalization of the poor, financing their care in part by city reimbursements and in part from the hospital's endowment. It was upon Hartford Hospital, then, that care of the tubercular devolved.

In 1895, hospital officials publicly recognized for the first time that something would have to be done about patients with tuberculosis:

In the near future we must have isolated buildings for the treatment of consumption. We have had some severe lessons as to its contagious properties, and if we must care for this class of patients, we must do so at as small risk of its conveyance to others as possible. There is no necessity of an elaborate ornamental structure, but ... a plain roomy building is what is needed.¹⁷

In this first of what would be eight years of annual pleas before the hospital's sanatorium, Wildwood, was built, a theme which will recur throughout the hospital's efforts to care for the consumptive already appears. There is a reluctance to undertake the task, and whatever care is given is to be economically provided. This unenthusiastic commitment would result in an underfunded "plain" establishment on hospital property at the edge of the city; the obligation to care for these undesirable patients would be eagerly handed over to the state as soon as state sanatoria were built.

It should also be noted that consumptives were no more enthusiastic than hospital officials about institutionalization, and resorted to it only as a last resort. In 1901, 33 of 52 (63%) the hospital's tuberculosis cases died, an indication that admission was often delayed until the disease was terminal. A survey of 1901 death certificates for Hartford residents indicates that only 24% of deaths from tuberculosis occurred in the hospital

¹⁷Hartford Hospital Annual Report, 1895, p. 17.

or almshouse.¹⁸ People died at home if they could, but families like the Barbellas probably lacked even the meager resources necessary to make that choice.

WILDWOOD SANATORIUM

Something had to be done, for "[e]veryone of these poor patients is by reason of his circumstances unavoidably and inevitably a source of infection to others" and it was necessary to "diminish as much as possible the breeding places of this most deadly of all human maladies."¹⁹ Consumptives had to be separated from the rest of society to protect the healthy, treat the disease (if it was in the early stages and still treatable), and teach the patient to live in such a manner that he did not endanger others. The best place in which to accomplish these goals was a sanatorium, declared the Connecticut Board of Health, and the fees of the poor in such facilities should be publicly funded.²⁰

Hartford Hospital's annual report had pointed out the need for an institution for the tubercular every year since 1895, so such talk in legislative chambers prompted a quick response. Members of the board appeared before the appropriation committee to ask for money towards construction of the sanatorium the hospital had

¹⁸The percentages are stable at least for the years 1901 - 1903, the only years for which I was able to read all Hartford death certificates. In 1902, 28% and in 1903 23% of TB deaths occurred in hospitals or the almshouse. Nine to eleven percent of deaths in the city and 12% to 13% of deaths at Hartford Hospital were from tuberculosis.

¹⁹State Board of Health Annual Report, 1900 (New Haven: Tuttle, Morehouse and Taylor, 1901), p. xxii.

²⁰Ibid., pp. xxi - xxiv

decided to build on the outskirts of Hartford.²¹ Board member Louis Cheney asked the state for help in establishing "a sort of an experimental hospital" so that tuberculous patients could be "isolated from the common run of patients in a hospital." He reminded legislators that an earlier investigating committee had concluded that rather than one large state-wide facility, it would be better to have "smaller institutions started in different parts of the state in conjunction with the hospitals that are already established."²²

After a discussion of charges to the state for the treatment of indigent patients it supported,²³ Dr. Root of Hartford Hospital assured the legislators that the proposed sanatorium would be for "all cases" of tuberculosis, not just the incipients. Already

²¹Whether or not Wildwood was planned before state funds became a possibility is unclear. Members of the hospital's board may have been quietly lobbying for years, and when they thought the timing right they began to raise money from Hartford citizens and soon thereafter approached the legislature. They may have been privately assured that their appeal would be looked upon favorably. Documenting such understandings among the small, interconnected ruling class of the city and state is almost impossible.

²²I could not locate the report of the first investigating committee to which he referred. For Cheney's testimony: General Assembly of the State of Connecticut, Public Hearing of the Joint Standing Committee on Appropriations [Stenographer's notes], 1903, p. 403.

²³The state was to pay \$4.00 per week, considerably less than the regular fee of \$7.00 [or \$8.00, quoted elsewhere in the hearings]. Hartford and other towns would pay the same amount for their indigent. It is not clear for which patients the state paid, since towns were supposed to pay for their own residents. In 1903, Hartford Hospital treated patients from 84 towns (and charged all \$4.00 per week). See General Assembly of the State of Connecticut, Public Hearing of the Joint Standing Committee on Appropriations [stenographer's notes], 1903, p. 403.

\$14,000 towards the projected construction costs of \$40,000 had been raised by the citizens of Hartford, he went on, and \$25,000 from the state would complete what was needed. He also averred that even if more money than requested was forthcoming, the proposed size of the sanatorium would not be increased, though the building might be built of brick instead of less expensive wood.²⁴ Having raised \$47,804.67, the hospital's board began construction. There was a slight budget overrun (construction cost \$46,617.95 and furnishings \$4,605.97), but no one was too concerned and Wildwood Sanitorium opened on May 1, 1902. It was staffed by a head nurse and eight regular nurses, two orderlies, three maids, a cook and an engineer. Medical attention was provided by a member of Hartford Hospital's medical house staff who was there from 8:00 a.m. to 6:00 p.m. daily.²⁵

Situated off New Britain Avenue on the southwest side of the city, Wildwood had the requisite altitude (it was on Cedar Mountain), view and rural atmosphere thought to be essential to recovery. The Hartford Courant rhapsodized,

²⁴General Assembly of the State of Connecticut, Public Hearings, Joint Standing Committee of Appropriations [stenographer's notes] (January Session 1901), pp. 405 - 410. The state also assisted voluntary hospitals in the major cities with biannual grants which were the same each year and were not discussed by the appropriations committee. Hartford Hospital's grant from this source was \$10,000, the same amount given to all large hospitals. Some smaller ones received \$5,000. See Public Acts, State of Connecticut for the relevant years (1901, pp 1405-6; 1903, p. 202; 1909, p. 1040, etc.)

²⁵Hartford Hospital Board of Directors Minutes, 1902, p. 36-40; Hartford Hospital Annual Report, 1902, pp. 19-20.

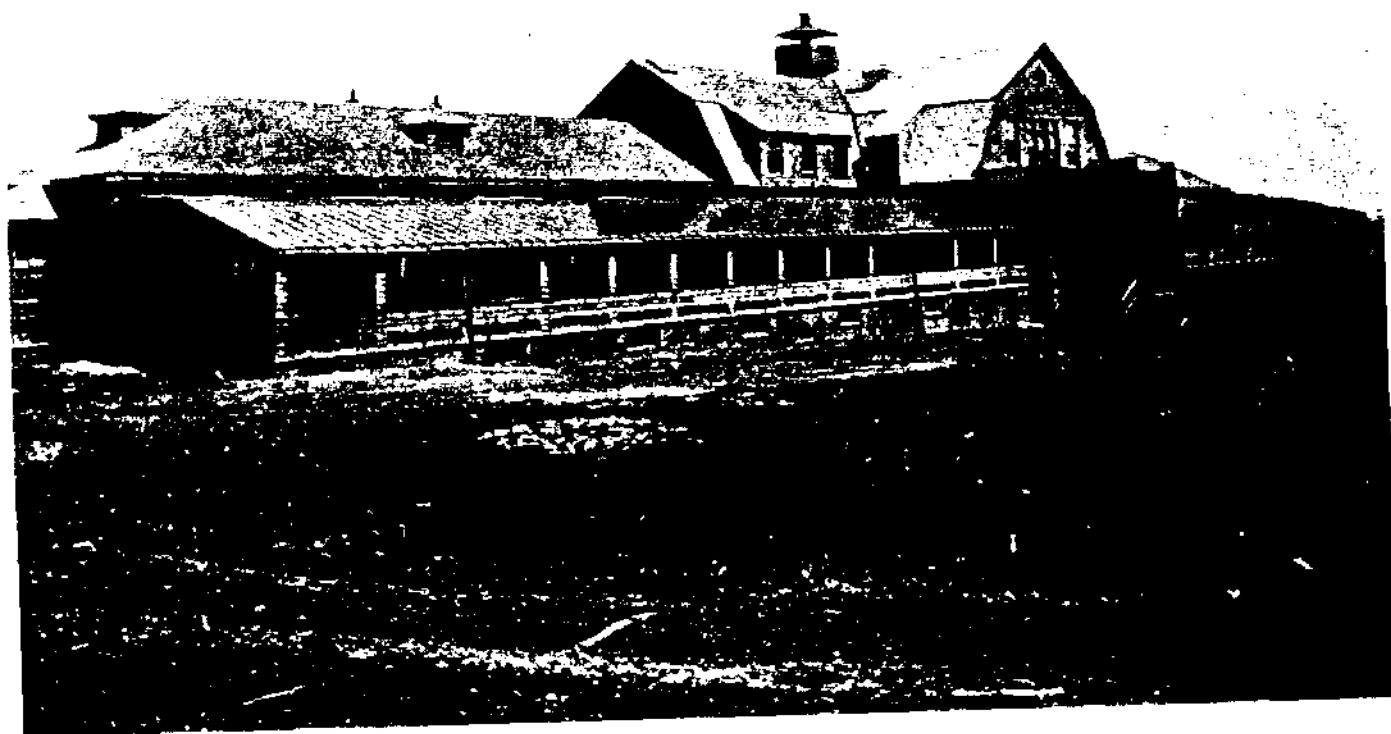


Figure 3: Hartford Hospital's Wildwood Sanatorium c.1905
[Hartford Hospital Archives]

It has a fine elevation, is on dry soil and the surroundings of cedars add a healing fragrance to the atmosphere. The view is superb, covering a wide range in all directions, and is really one of the most beautiful spots in the vicinity of Hartford.²⁶

The building, designed for fifty patients, was a large gambrel-roofed, barn-like structure. [See illustration in figure 3, opposite.] A two story central section for administration, kitchen and dining and bathing facilities was flanked by two one story wings which contained the men's and women's wards. Each wing had a south-facing "veranda" thirty feet long which was roofed but otherwise open to the air. The wards were simply large rooms with tall windows; the iron beds were lined up along the sides, six to eight feet apart. Each wing had three private rooms as well.²⁷

Although things seemed to begin well, there were ominous signs of trouble. The first four months revealed problems in running Wildwood, some of which Hartford Hospital never solved. By the end of September the average daily census was 27, and 69 individuals had been treated. The sanatorium was not full, and patients did not stay long. Furthermore, of the patients that had been discharged, only 12 were considered improved, while 18 were unimproved and 12 had died. These were not hopeful statistics. Finally, the hospital found that the actual cost per week per patient was \$9.65, but the average income from each patient was \$3.98. The financial shortfall was considerable.

²⁶Hartford Courant (May 1, 1902) p. 13.

²⁷Ibid. The article features several exterior and interior photographs in addition to a description in the text.

There were other portents of impending trouble which originated in the parent institution but would have serious consequences for Wildwood. Even as the sanatorium opened, Hartford Hospital was running a deficit and had to appeal to the public for help. The \$74,800 raised in the spring of 1902 covered the debt, but it was clear that administrative changes would have to be made. Significantly, one of the directors argued for a need for a separate part of the hospital to treat private patients. Although this request was tabled, attempts to attain financial stability meant that in the future attention would be paid to what was necessary to attract paying patients.²⁸

In November 1903, after it had been open for only 18 months, Wildwood Sanatorium closed. In its annual report for that year, Hartford Hospital explained that original proposal for the sanatorium had been that it treat only incipient cases (although this is not what hospital representatives had told the state appropriations committee). A fundamental mistake had been made by admitting too many "hopeless" cases. "The mortality therefore has been great, and the recoveries few," confessed the hospital spokesman.²⁹ Indeed, of the 140 people admitted over the course of the preceding year and a half, only 14 had been classified "incipient" or "early stage." Mortality had been high, with 37 (26%) dying.

²⁸On the need for facilities for private patients, see Hartford Hospital Board of Directors Minutes, Nov. 30, 1901, p. 333 and Dec. 18, 1901, p. 334. On the debt, see Hartford Hospital Board of Directors Minutes, Jan. 30, 1902, p. 36; March 3, 1902, p. 37; March 29, 1902, p. 39.

²⁹Hartford Hospital Annual Report, 1903, pp. 21-22.

And sicker people cost more to care for -- the average cost per week per patient had increased to \$10.08. The Connecticut Courant summed up the situation crudely but succinctly. After noting that the finances at Wildwood "had run behind about \$15,000 so far," the reporter got to the point:

To a large extent it [Wildwood] has been used as a comfortable place for hopeless cases to die at. The design of that method of treatment has been to take the incipient cases and drive the disease out. But ... town managers have not sent patients at even the low price of \$4 a week to the hospital, when at \$2 or less they could be kept about the poorhouse, and so the sufferers have been kept away until too late and have been sent there only when all broken down. Thus ... the occasional incipient case has cleared out as soon as possible rather than stay by amid so many signs of extreme exhaustion and coming death.³⁰

Hartford Hospital's problems were bigger than the failure of Wildwood, however. The financial situation had not improved even though closing the sanatorium cut receipts by \$5,000 and expenses by \$16,000³¹ Massive reorganization of the hospital began as the executive committee of the board assumed direct daily management of the troubled institution. Committee members found chaos and waste wherever they looked. They instituted vigorous administrative reforms in everything, from the hour at which house staff were expected to breakfast, to closing the ice making operation, to instituting a better bookkeeping system and raising hospital fees. By the end of 1904 members of the executive committee began to turn

³⁰Connecticut Courant (November 9, 1903), p. 7. The Hartford Courant did not cover the closing of Wildwood.

³¹Hartford Hospital Annual Report, 1903, p. 23-4.

over most day-to-day responsibility for running the hospital to a newly hired superintendent.³²

By early 1905, the executive committee again identified a need for a facility to treat consumptive patients. After considerable discussion and analysis of fund raising possibilities, they voted to recommend that Wildwood be reopened, a recommendation accepted by the full board on August 1.³³ On October 1, 1905, Wildwood Sanatorium reopened.

Why, after such a disastrous first try and when the newly reorganized institution was still consolidating the changes the board had made, did the executive committee embark again upon establishing a sanatorium? First and most important, financing was available. The State of Connecticut provided \$15,000³⁴ and John Gunshanan's Workingmen's Free Bed Fund provided substantial

³²Although it can only be touched upon here, this period in the history of Hartford Hospital is of great importance in understanding how it made the transition from a nineteenth century to a modern institution. Members of the executive committee were: William Morgan, MD; Thomas Sisson [replaced by George C.F. Williams]; Louis Cheney; Phineas Ingalls, MD; Gilbert Heublein and H. Howard Morse. Their investigations into current conditions at the hospital and recommendations for change were detailed and far-reaching. See Hartford Hospital Executive Committee Minutes, December 16, 1903 [when they begin] to December 21, 1904 [when the emergency was under control].

³³See Hartford Hospital Executive Committee Minutes, 1905, pp. 57, 64-5, 67; Hartford Hospital Board of Directors Minutes, 1905, p. 79.

³⁴As before, this was to last for two years. Public Acts, State of Connecticut, 1905, p. 575. The hospital received one more grant, \$40,000 this time, to cover 1907 - 09. Public Acts, State of Connecticut, 1909, p. 932.

assistance as well.³⁵ In addition, the city of Hartford had converted some space at the almshouse into a "city hospital" largely to care for the consumptives Hartford Hospital had refused for the period of the Wildwood shut-down, but potentially for the care of all city-funded patients. (See Chapter II, above.) We cannot know whether this specter of competition for patients and funding from the city was a factor in the decision to reopen Wildwood, but the timing of the closing of Wildwood, opening of the city hospital and subsequent reopening of Wildwood is suggestive. Finally, Hartford Hospital was still attempting to attract private patients.³⁶ If consumptives had to be admitted, it would be better to organize their care so they were confined to specified parts of the hospital. As was to become apparent later in the decade, even this did not assuage the fears of the paying patients, but in 1905 it seemed a good compromise.

At the reopened Wildwood, care of patients was managed differently from what had been done in 1902-03. Hartford Hospital set aside two wards³⁷ in the hospital proper for "chronic" cases, while "incipients" were sent to the sanatorium. Wards four and eleven and Wildwood together were to be considered the "Tubercular Hospital" and their funding and staffing were to be kept separate

³⁵See Chapter IV for a fuller discussion of this matter. The fund provided \$13,158.50 between 1905 and 1907.

³⁶Hartford Hospital Executive Committee Minutes, 1904, July 8, p. 37. The committee voted to "accept patients who wish [a] private room and special nursing for \$35.00 a week."

³⁷Originally wards three and four, later wards four and eleven.

from the general hospital. Applicants for admission had to apply to the main hospital for examination and classification. They were admitted to the chronic wards and then transferred to the "annex" [Wildwood] if their conditions warranted such optimism. There were 40 ward and eight private beds at Wildwood and 42 ward and two private beds in the main hospital.³⁸

The first two years were troublesome and must have worried Hartford Hospital's Board greatly. By 1907 the deficit was \$22,836.43 and there was little hope of finding a permanent solution. The Workingmen's Fund was in debt to the hospital (and would soon cease to contribute at all) and a new state appropriation of \$40,000 for 1907 - 09 was achieved only at the cost of lowering the fees to state patients to \$6.00 a week.³⁹

There were other problems as well. Staffing the tubercular units had proved difficult. Student nurses (then a major source of nursing staff) had to be replaced on the chronic wards by graduate nurses, a much more expensive proposition. Tuberculosis nursing did not appeal to local nurses; Agnes Kernan was imported from Johns Hopkins to be matron at Wildwood and a new graduate of the Phipps Institute in Philadelphia, Mary Tierney, was hired to be head nurse of the most difficult chronic wards. Tierney was probably a recovered consumptive, since the training program at Phipps, a prominent center for the study of tuberculosis, recruited

³⁸Detailed in Hartford Hospital Annual Report, 1905, pp. 42-3.

³⁹Hartford Hospital Annual Report, 1907, pp. 20 - 24.

ex-patients as students.⁴⁰ In 1907 the annual report recapitulated the staffing problem:

[The Tubercular Division] continues and will continue to be the source of many of our worries, on account of the difficulty in handling the patients to their satisfaction and the difficulty in obtaining a competent corps of attendants and ward helpers. The attention demanded by these patients, particularly the advanced cases, is almost unlimited. Wards 4 and 11 are filled to their full capacity all the time and usually there is a waiting list.⁴¹

The new system of allocating patients by disease classification soon broke down, if it ever worked except to exclude the most debilitated from the sanatorium. First, a large minority of patients did not stay even one month -- in 1907, twenty-two left in the first 30 days.⁴² Then, "incipients" were difficult to attract: Of the remaining 57 patients, 28 were classified "moderately advanced" or "advanced." People were not allowed to die there, however -- they did that elsewhere in the hospital. Tuberculosis mortality data for Hartford Hospital are difficult to interpret accurately, but 57 deaths from tuberculosis were reported

⁴⁰Barbara Bates, Bargaining for Life: A Social History of Tuberculosis, 1876 - 1938 (Philadelphia: University of Pennsylvania Press, 1992), pp. 110-2.

⁴¹Hartford Hospital Annual Report, 1907, p. 58. For excusing student nurses from staffing wards 4 and 11, see Hartford Hospital Executive Committee Minutes, December 8, 1907, p. 112.

⁴²This is the only time in the Wildwood statistics that the number leaving so soon was given. Usually, Wildwood conformed to the customary way of presenting data in which patients were not counted until after they had been institutionalized for a month. [see Chapter I, above]

in 1907, and none of them occurred at Wildwood.⁴³ Whether by death or discharge, the turnover on the chronic wards was much more rapid than at the sanatorium, although slower than on the general wards.⁴⁴ Since these were the patients who were not expected to get better, one assumes that they either died in the hospital or were taken home when the outcome was clearly hopeless.

After 1908 there was some improvement. Wildwood beds were full. The executive committee hired a full-time, resident physician for the sanatorium, William Bartlett, a graduate of Harvard Medical School with sanatorium experience at Saranac and Stony Wold, two important establishments in the Adirondacks. Under his administration, admission procedures were simplified and discipline tightened. Average length of stay at Wildwood increased to 116 days in 1909⁴⁵, a positive sign. The daily cost per patient decreased to \$1.37 (\$9.45/week) from 1907's rate of \$1.55

⁴³For an example of the problem, see Hartford Hospital Annual Report, 1907. Page 80, which gives statistics for the hospital as a whole, indicates 196 tuberculosis cases of which 57 died. On page 59, however, 252 cases are said to have been treated on wards 4 and 11 and an additional 153 at Wildwood, for a total of 375 cases. It is possible that transferring people back and forth between the wards and Wildwood meant that individuals were counted several times. To add to the confusion, death certificates for city patients who died at Hartford Hospital list all, whether dying of tuberculosis or another disease, as dying on ward seven! Hartford Hospital's archivist is as baffled by this last discovery as I. (telephone interview with Steve Lytle, December 10, 1992.)

⁴⁴Average length of stay on wards 4 and 11 was 48 days, for those at Wildwood 93 days, for general hospital patients 23 days. Hartford Hospital Annual Report, 1907, pp. 52, 59.

⁴⁵Hartford Hospital Annual Report, 1909, p. 151, 154.

(\$10.85/week)⁴⁶ so that although the deficit continued, it grew at a slower rate. People with early disease still were not coming for care in large enough numbers -- in 1909 only 27% of admissions were so classified, and a third of all patients left before the three months thought to be the minimum necessary for effective treatment.⁴⁷ On the whole, however, there was hope for the future.

If things were improving at Wildwood, the situation at the main hospital remained difficult. Running the two wards for chronic consumptives was increasingly expensive, as the hospital's daily average cost per patient of \$1.89⁴⁸ was offset by a payment of only \$1.00 a day from the city.⁴⁹ Worse, the presence of tubercular patients at the main hospital "influences many other patients not to enter the hospital," in the opinion of the board.⁵⁰ Private patients were a growing source of revenue, and the board looked forward to the time when the state institutions "will take all our advanced cases. When this is accomplished one prevailing ... objection to private patients coming here will be removed."⁵¹

⁴⁶Hartford Hospital Annual Report, 1909, p. 60; Hartford Hospital Annual Report, 1907, p. 59.

⁴⁷Hartford Hospital Annual Report, 1909, pp. 151, 154.

⁴⁸Ibid., p. 60.

⁴⁹City rates had been renegotiated in 1907. See Hartford Hospital Executive Committee Minutes, 1907, p. 102.

⁵⁰Hartford Hospital Annual Report, 1908, p. 55.

⁵¹Hartford Hospital Annual Report, 1909, p. 59.

It is thus not surprising that Hartford Hospital's Board of Directors was not displeased when, at the end of 1908, the State Tuberculosis Commission recommended that a state system of sanatoria be erected. (This is discussed more fully in Chapter IV.) Physicians and administrators at Hartford Hospital were eager to close the main hospital's wards for advanced consumptives and pleased that the state would open facilities that would accept such patients. When the state sanatorium opened in Newington in the spring of 1910, wards four and eleven at the main hospital were emptied and refitted for other uses. Wildwood's census dipped briefly as patients funded by public monies were transferred to Cedarcrest, but rebounded quickly, and by the fall of 1910 the deficit of the tubercular department, now consisting only of Wildwood, was down to \$2,238.95.⁵² By 1912, the executive committee was happy to report that a fifth of all admissions to Hartford Hospital were private patients who paid fully for their care and even provided the hospital with a \$12,000 profit.⁵³

Mary Tierney, the Phipps nurse who had been brought to Hartford to run the chronic tuberculosis wards, was admitted to Wildwood as a patient in November of 1910. Her fees were paid by

⁵²Hartford Hospital Annual Report, 1910, p. 46.

⁵³Hartford Hospital Executive Committee Minutes, 1912, p. 53.

the hospital.⁵⁴ In 1912 she left Hartford for New York,⁵⁵ and it is not possible to trace her further.

CONCLUSION

The Board of Directors of Hartford Hospital attempted to solve the problem of how to care for poor tuberculosis patients by setting aside space and staff separate from but still controlled by the main hospital. In isolating tubercular patients from others they were following what was accepted medical practice both then and now. They did not, however, commit sufficient resources to the tuberculosis facilities for them to develop into a self-sustaining, vital institution. It is instructive to compare Wildwood with Gaylord, in Wallingford, a sanatorium which opened at around the same time and achieved a reputation for excellent patient care.

Gaylord Farm Sanatorium opened in the fall of 1904. Unlike Wildwood, it was not part of an existing hospital, but was sponsored by a group of New Haven physicians and citizens who had joined to form a New Haven County Anti-Tuberculosis Association in 1902. This dedicated group raised private money and obtained funding from the state as well, as Wildwood had. The medical director, Dr. David Lyman, who received his tuberculosis training from Dr. Trudeau at Saranac, proved to be energetic and resourceful. He was convinced that patients should return to their old jobs upon discharge and kept careful follow-up data proving that

⁵⁴Hartford Hospital Executive Committee Minutes, 1910, p.144.

⁵⁵Hartford City Directory, 1912, p. 656F. This was probably New York state, as the directory usually specified "New York City" when that was the destination.

they did better at those than at the outdoor employments that were commonly advocated. This good news earned him publicity both locally and nationally, and his institution benefitted.⁵⁶

Although Gaylord's records were not available for this study, its director seems to have been more successful at mobilizing resources to support his hospital. It remained in the forefront of treatment, adopting new modalities as they came along, adding new buildings and facilities as they were needed. When antibiotics made sanatorium treatment of tuberculosis unnecessary, Gaylord's physical plant was used for other medical purposes -- it is now a center for physical rehabilitation. Wildwood, on the other hand, continued to operate at a loss and closed quietly in 1939 because of low occupancy.⁵⁷

Gaylord benefitted from being the sole responsibility and interest of its Board of Directors. It was not, as Wildwood was, a bothersome subsidiary always with a nagging deficit to be made up, a distraction from the more important (and profitable) project of improving patient care and attaining technical sophistication for a rapidly growing general hospital. This is not to accuse

⁵⁶David R. Lyman, "From Consumption to Tuberculosis in Connecticut," The Heritage of Connecticut Medicine (New Haven: Connecticut Medical Society, 1942), pp. 188 - 201. That Lyman, director of Gaylord, was chosen to write the article is an indication of his prominence in state medical circles. The tuberculosis literature of the 1905 - 35 period contains many papers by Lyman, and even a few by Florence Burgess, the nurse who ran Gaylord with him until her death in 1939.

⁵⁷File in Hartford Hospital Archives: "Allen, William -- Wildwood Sanatorium." The sanatorium building was torn down, and the site now houses a retirement complex, Avery Heights. Most residents do not know that there ever was a sanatorium there.

Hartford Hospital's Directors of malevolence towards or willful neglect of tubercular patients. To the contrary, that Wildwood remained open as long as it did, never raising its rates higher than the \$7.00 a week they had been since it opened, speaks well of the parent institution's willingness to continue a program that served so few. Demographic data for Wildwood's patients is unavailable, but it must have been a haven for people unable to pay for care at far away, expensive sanatoria but willing to make a modest financial sacrifice rather than send a loved one to a state institution.

Dr. Lyman was clearly the right person at the right time for Gaylord's success, but his power was enhanced by being in full charge of a facility that was dedicated to only one purpose. Wildwood's medical directors had to compete with other departments for funding, staffing and attention, and care of the tubercular was not a priority as Hartford Hospital evolved into an increasingly complex operation.

Wildwood and Gaylord thus presented conflicting evidence of the success of privately managed sanatoria. Both had received generous state funding, and it must have been clear to legislators that they would continue to require considerable public support. Given the equivocal results of this first attempt by the state to ensure that indigent consumptives received adequate care, it is not surprising that a State Tuberculosis Commission was appointed in 1907 to investigate and recommend other approaches to the problem. The findings of this commission, and the participation on it of a

representative of working class people is the subject of the next chapter.

CHAPTER IV

CHARITY, POLITICS AND TUBERCULOSIS

Most historians agree that one of the agendas of progressive era reform was to control immigrants and the urban working class. A related question is whether and how the targets of social welfare were able to affect decisions which influenced their lives, such as what kind of treatment they might receive should they contract tuberculosis. The urban poor probably had little energy to devote to even attempting to understand legislation and initiatives undertaken by social workers and bureaucrats on their behalf, but labor unions and city political machines represented and negotiated working class interests.

A history of the labor movement in Hartford has yet to be written, but in the first decade of this century such unions as there were (and the movement seems not to have been strong)¹ were apparently unable to address matters of health.² There is no

¹The union movement at the Cheney silk mills in nearby Manchester, for example, had been crushed by 1902. See John Sutherland, "'One Loom or No Looms!': The Cheney Velvet Weavers' Strike of 1902 and the Limits of Benevolent Paternalism" Connecticut History 33 (November 1992): 1 - 37.

²They had more immediate worries about the dangers of the workplace -- it took until 1913 for Connecticut to pass a Workmen's Compensation Law. See Robert Asher, "Connecticut's First Workmen's Compensation Law", Connecticut History 32 (November 1991): 25-49. Even paternalistic employers were reluctant to pay compensation for accidents, and sick benefits were not a consideration at all. See Robert Asher, "The Limits of Big Business Paternalism: Relief for Injured Workers in the Years before Workmen's Compensation," in Dying for Work: Workers' Health and Safety in Twentieth Century

evidence in Hartford that "labor joined with middle-class reformers to argue for a new definition of the intimate relationship between the health of workers and the health of the general community," as happened elsewhere.³ Even in those places in which labor and reformers did raise the issue of tuberculosis, the focus was upon a healthier workplace, not assistance for sick workers.⁴ At least before 1910, organized labor did not initiate discussions about what kind of care should be available for consumptive workers.

The other obvious voices for sick workers were their benevolent associations. These, connected with fraternal groups or places of employment, might have tried to negotiate on behalf of their members; indeed, Hartford Hospital documents indicate that one such group, the Workingmen's Benevolent Association,⁵ did raise money to subsidize care of its consumptive members at Wildwood. John Gunshanan, chief fund raiser of the WBA, is of special interest in the context of this paper, for the governor of Connecticut appointed him to be one of the first tuberculosis commissioners in 1907. Gunshanan's evolution from supporting a

America, eds David Rosner and Gerald Markowitz (Bloomington: Indiana University Press, 1987), pp. 19-33.

³David Rosner and Gerald Markowitz, "The Early Movement for Occupational Safety and Health, 1900-1917," in Sickness and Health in America, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1985), p. 515.

⁴Ibid. Nowhere in the article cited is there mention of sickness benefits. Workmen's Compensation Laws paid for injury, not illness.

⁵It was not a typical benevolent association, however, as will be discussed below.

small, local sanatorium to advocating a system of state institutions parallels the change in public policy regarding sanatorium care for the poor. It also exemplifies how representatives of working class interests could align themselves with mainstream reformist thinking.

Gunshanan was probably appointed to the Tuberculosis Commission because of the political position enjoyed both by himself and by other members of his family, especially one of his brothers, Michael. Michael rose from almshouse storekeeper to city charity commissioner, a progress which illustrates how dispensing public charity could be a route to economic stability and political power. The careers of both men demonstrate that patronage jobs in the new bureaucracies offered opportunities for members of the rising working class to influence the ways in which policies were actually implemented; this was particularly true in agencies which dispensed charity. Further, holders of some patronage jobs, such as tuberculosis commissioners, both created and carried out public policy. Appointees to such positions could express the concerns of workers and directly affect their lives as well.

Although there is no information about how Hartford's patronage system worked, it is evident that in other places the stakes could be very high indeed. In 1916, the director of Chicago's municipal sanatorium committed suicide because he had been forced out of his position after a dispute with a new mayor

over the awarding of contracts for supplying the sanatorium.⁶ Considered as businesses with money to spend and therefore power to wield, both the almshouse and the sanatorium could be bases for political influence and personal aggrandizement.

The Gunshanan brothers are examples of the "making good" story so common in American folklore. Their lives are recounted in detail to provide a flavor of social mobility in turn-of-the-century Hartford and to illustrate how representatives of the working class became participants in progressive social reform.

THE GUNSHANAN FAMILY

The patriarch, James Gunshanan,⁷ first appeared in the Hartford City Directory in 1866, living in the back part of 44 Temple Street and working as a porter.⁸ Temple Street was in the heart of downtown Hartford's tenement district, and James spent his

⁶Graham Taylor, "The Civic Martyrdom of Dr. Sachs," The Survey 36 (April 22, 1916): 106-6; "The Death of Dr. Sachs," The Modern Hospital 6 (May 1916): 343-4.

⁷The surname is variously spelled Gunshanan, Gunshannan, Gunshanon, etc. at different times. I have used Gunshanan throughout because that is how John Gunshanan spelled it when the Tuberculosis Commission of which he was a member published its findings in 1908.

⁸I have pieced together the story of the Gunshanan family by following them in the City Directories and manuscript censuses. To cite every fact gleaned from these sources would be laborious for reader as well as author, so this general footnote will cover the entire section. I consulted the Hartford City Directory for every year between 1866 and 1981 (when the last remaining members of the family vanish from the city). The U.S. Census for the years 1880 (reel 98, enumeration district 19, sheet 33A), 1900 (reel 137: enumeration district 179, sheet 6A & B, 13A; e.d. 180, sheet 2B; e.d. 184, sheet 16B), 1910 (reel 133: enumeration district 176, sheet 4A; e.d. 183, sheet 19B; e.d. 191, sheet 23B; e.d. 193, sheet 5A).

first few years at various addresses in that neighborhood.⁹ He had come to the United States in 1857 at the age of 18, and had first lived in New York City, where he met and married Elizabeth (Bridget) Riley, also an immigrant.¹⁰ They were accompanied to Hartford by his brother Bernard, a teamster who owned his own business. Bernard left the city after a few years and James acquired the business, an ideal one for making the acquaintance of people of all social backgrounds.

By 1878, James, Bridget and their now large family had moved to 19 Affleck Street, near Zion Cemetery in the 8th Ward, away from the tenements of their first years. They were to remain in this neighborhood for the rest of their lives, and when their male children became independent, they also remained in Frog Hollow, as that part of the city was (and is still) known.¹¹ When the Gunshans moved to Affleck Street, they moved out of the ethnically mixed tenement district and into an almost purely Irish community, among people with surnames such as Boyle, Farley, O'Neill, Booley. Most men were skilled workers: stone masons, carpenters, machin-

⁹Information about neighborhoods is from reading the census sheets for adjoining buildings and streets and from consulting the Atlas of the City of Hartford CT (Springfield MA: L.J. Richards & Co., 1896 and 1909). These atlases are very detailed, providing the researcher with information such as the material from which a structure was built (stone, brick or wood), whether it was detached or a row house, how large its lot was, and whether there were outbuildings. Names of property owners are indicated, as well as of factories, churches, schools and large stores.

¹⁰Mrs. Gunshanan identified herself as "Bridget" to census enumerators and in the city directory after she was widowed.

¹¹I was only able to trace children who retained the Gunshanan name -- the six males, since all daughters married.

ists. The Gunshanans seem to have fit in well; their family was a little larger than most, and Bridget told the census enumerator that she could both read and write, accomplishments not attained by many of her female neighbors, though almost all men were literate. They were a hard working, sociable and intelligent family.

In 1880 several incomes contributed to the support of the Gunshanan family. The census taker found James and Bridget with eleven children (the twelfth would be born in 1883) ranging in age from 3 to 21. The three oldest children were employed: Michael, 21, was a screw maker; Mary, 17, was working in a shop; her twin, Thomas, worked in a machine shop, probably hoping to emulate his older brother in a skilled trade . The younger children were all at school. Between 1880 and the next census record in 1900, James purchased a home 20 Affleck Street. The "express business" was his, and he "numbered among his friends some of Hartford's leading citizens."¹² James' influence was informal, but it probably prepared the way for the next generation to reap the rewards of political patronage.

Thomas, the second oldest son, either benefitted from his father's political connections or forged his own. However he managed it, he began the public service which would assure middle class status for both himself and other family members. Having worked as a screwman like his older brother, he married around

¹²Mary Morris Obituary Scrapbook, volume 59, p. 32. [at Connecticut Historical Society].

1885, and moved around the corner to 67 Ward Street in 1889. In this year, at the age of 27, he became a city councilman. Between 1889 and 1895 he served three terms as councilman (during one he was the president of the common council) and then two terms as alderman, representing the eighth ward in both cases. He was politically active and influential for all of his long life; his 1950 obituary called him the "Mayor of Frog Hollow." His reward for meritorious civic service was a job was in the customs department, which he entered as a clerk in 1896; by 1900 he was Deputy Customs Collector and eventually became the Deputy Commissioner of Customs for Connecticut in 1925. An appointment that would be of importance to his brothers, however, had occurred in 1895, when he served briefly on the Board of Relief (which would become the Board of Charity Commissioners the following year.)¹³ Although Thomas did not continue to hold a position on this board, he may have been there long enough to secure a position on the staff of the almshouse for his brother, Michael.

The oldest Gunshanan son, Michael first appeared in the city directory as "almshouse storekeeper" in 1897, and although there is no proof, it is surely not a coincidence that his brother Thomas had been, however briefly, a member of the Board of Charity

¹³This information is from his obituary, Hartford Times, February 6, 1950, p. 22. His political career, which will not further concern us here, was distinguished. He was active in Democratic politics all his life. He chaired the Washington Street School District in 1914 (serving on the district board from 1900 to 1921), and was later involved in the planning and building of Bulkley and Weaver High Schools.

Commissioners¹⁴ and that his father knew some of "Hartford's most influential men." Michael was around 37 years old at the time of his appointment, as yet unmarried. (He was to marry at the age of 45, in 1905.) Michael's title soon changed from "Keeper of the Storehouse" to "Investigator for the Charity Board," but probably his daily activity did not change. He was the one who decided which applicant would receive what at the almshouse, a position of enormous power and influence. He was apparently not a rigid bureaucrat, for "while a strict observer of the laws governing the charity department, many a time his big heart superseded certain provisions of that law, because no man, woman or child that met him ... left without receiving aid."¹⁵ By the time of his death in 1926, he had become President of the Board of Charity Commissioners. His involvement with and power within the charity bureaucracy may account for the tuberculosis-related work of his younger brother, John, the fourth son and sixth child of James and Bridget. It is he with whom this paper is most concerned.¹⁶

¹⁴Michael's obituary says he was "city storekeeper" beginning in 1892. This may be an error, or his brother or father may have obtained the position for him that early. The city directory does not list him as "storekeeper" until 1897. His obituary appears in Hartford Times, April 5, 1926, p. 20.

¹⁵Ibid.

¹⁶This accounts for 3 of the 6 sons (Thomas the Customs Commissioner, Michael the Charity Commission Investigator, and John who will be discussed at length below.) The other three were: James, an expressman and printer, remained single and lived with his widowed mother until his death in 1921 at age 52; Terrance, a butcher and eventually the owner of a market, married late and died childless in 1941 at the age of 70; Joseph, who worked for an ice cream and soda company and died unmarried at 29 in 1904. Bridget, their mother, lived first with James and then with a widowed

John was born in 1868 and was nine years younger than Michael and five younger than Thomas. He must have worried his hard working family, for his early adult years seem to have been rather aimless. The city directory listed him as a printer between 1883 and 1887, when he was between 15 and 20 years old; this was probably an apprenticeship. The printing business did not attract him, for from 1886 to 1897 he was listed as a "baseballist." Apparently domestic responsibilities made it necessary to make another change, for in 1900, when he told the census enumerator he was a newspaper reporter, he had a wife and five children, aged one to seven. They lived at 17 Affleck, across the street from his parents. John's rented flat was in a small three story building¹⁷ with two other families; we have the impression of a not too prosperous growing family (two more children were to be born, though only five of the seven lived to adulthood), living in a crowded apartment in a decent working class neighborhood. However, although John may not have been financially very successful, he was beginning to be a presence on the political scene.

JOHN GUNSHANAN AND THE WORKINGMEN'S CLUB

In August of 1902, 34 year old John Gunshanan chaired the committee which welcomed President Theodore Roosevelt to Hartford. He presented a "mammoth floral horseshoe [given] by Hartford

daughter before dying at 86 in 1925.

¹⁷The building still stands, now numbered 165 Affleck. His parents' home, 20 Affleck, is now number 178. Atlas of the City of Hartford (Springfield, MA: L.J. Richards, 1920) plates 7 and 11.

workingmen" and was personally thanked by the President.¹⁸ Opportunities to participate in such a momentous event were not given to minor political figures. John must have had considerable standing in the Democratic party.

His power came, in part at least, from his leadership in an organization in which the mayor of Hartford, William Henney, was also involved, the Workingmen's Club.¹⁹ Exactly what this was is unclear, since no club records could be located, but it seems to have been a working class version of the Civic Club -- Gunshanan's obituary indicates that he and the club lobbied for public baths in Pope Park, all night trolley service, and other projects "to make conditions better for the people of Hartford."²⁰

We know with certainty of at least one thing the club did superbly well between 1903 and 1907: it collected the then considerable sum of \$11,000²¹ to pay for the institutional care of consumptive workingmen and the support of their families. The money was raised through a subsidiary organization, the Working-

¹⁸John Gunshannon [sic.] obituary, Hartford Times, August 5, 1930, p. 20.

¹⁹General Assembly of the State of Connecticut, Public Hearings before the Joint Standing Committee on Humane Institutions [typescript, stenographer's notes], (January session 1911), p. 39.

²⁰Hartford Times, August 5, 1930, p. 20.

²¹Dollar amount given by Gunshanan in his testimony. See: General Assembly of the State of Connecticut, Hearings Before the Joint Standing Committee on Appropriations [stenographer's notes], (January Session, 1907), p. 312. As will be mentioned later, Hartford Hospital acknowledged more than this, \$13,158.50.

men's Benevolent Association,²² the officers of which were skilled workers employed in Hartford factories: in 1905 they were three filers at the Colt factory, a toolmaker at Pope's, a Colt assembler and a "helper" at a home furnishings store at 61 Asylum.²³ The Workingmen's Fund, "started first in Hartford and promoted largely by the indefatigable work of Mr. John Gunshanan," raised money "by subscriptions from the men in the shops."²⁴ William Henney explained,

There was a good deal of [tuberculosis] in the shops and that West End [Workingmen's] Club took up the matter of the disease among their shopmates and they organized an association to fight it and they got the manufacturers interested in it. The result was that they passed the hat in the shop and took up a collection and contributed a certain amount and the manufacturers agreed to contribute as much as the workingmen. In that way they raised a large amount of money.²⁵

John Foster, an admiring New Haven physician, described Gunshanan and his work at a national tuberculosis symposium in

²²it was expended by "The Workingmens Fund" or "The Workingmens Free Bed Fund." How all the sub-groups related to each other is unknown.

²³Hartford City Directory, 1905, p. 973. This is quite unusual. Officers of all other "Benevolent Associations" (most large factories and even some stores had them) were from management. The official Colt Mutual Benefit Association's 1904 officers, for example, were a superintendent, a foreman, the purchasing agent, and the president of the company. [Hartford City Directory, 1904, p. 951] Entries in the directory listed names of the officers, cross-checking with their individual entries yielded their occupations or positions.

²⁴Report of Special Commission to Investigate Tuberculosis (Hartford: State of Connecticut, 1908), p. 44.

²⁵General Assembly of the State of Connecticut, Public Hearings before the Joint Standing Committee on Humane Institutions (1911), p. 39.

1908. Gunshanan went to "one of the largest manufacturing concerns," explained to the owner that he had a plan "for the relief of sufferers from tuberculosis in his neighborhood," and requested permission to solicit contributions from the men in the mill. Having secured their donations, he returned to the owner and "had the sum doubled through the generosity of the public-spirited proprietor." In this fashion all the factories in Hartford were approached and a large amount of money was raised.²⁶

A talented organizer and publicist, by 1908 Gunshanan was beginning to raise money for his cause throughout the state. Dr. Foster reported upon an event in New Britain which Gunshanan had arranged. Its owners donated the use of the opera house, a brass band gave a concert, the Governor of the State gave a short address, and after more music

Mr. Gunshannon [sic.] addressed the people in his own style, and he knows how to do it. I cannot do it as he does. It is well to leave the matter to him. After this introduction in New Britain, Mr. Gunshannon will go among "the boys," as they are familiarly called, find the right ones, and these will go to work as a committee in their town and do what they can under Mr. Gunshannon's guidance to secure voluntary subscriptions for their local fund. Next Wednesday an entertainment will be held in Bridgeport, and so the work is being carried throughout the state....²⁷

²⁶J.P.C. Foster, in a symposium "With a State Sanatorium Secured, What Next?" Transactions of the Fourth Annual Meeting of the National Association for the Study and Prevention of Tuberculosis (Philadelphia: William F. Fell Co., 1908), p. 57.

²⁷Ibid. Foster went on to describe [p. 58] Gunshanan's state wide fund-raising efforts, and it sounds like a prototype of today's United Way appeals in the workplace: "[Gunshanan] has prepared a card upon which the giver can signify how much he is willing to give, and with the permission of the proprietors of the factories he gives the superintendents packs of these cards, with

This was organizing at its most effective, except that the purpose was not the formation of a union or the election of a particular political candidate (although those goals may have been present as well), but an admirable (and ostensibly non-partisan) attempt to assist people with a dreaded disease. John Gunshanan proved he could mobilize people around this issue. He was rewarded by an appointment to the State Tuberculosis Commission when it was formed in 1907.

The appointment must have been approved by the medical community, which also appreciated Gunshanan's activities and publicly recognized him for them. In 1905, Hartford Hospital's Board of Directors passed a resolution in appreciation of the "intelligent, energetic and successful efforts of Mr. John F. Gunshanan toward establishing and organizing the Free Bed Fund for the Tuberculosis Hospital at Cedar Mountain [Wildwood]."²⁸ Recipients were also aware of his work on their behalf; patients at Wildwood awarded him a "gold badge" of gratitude in 1907.²⁹

The money Gunshanan raised was in fact of substantial assistance in the early years of Wildwood Sanatorium -- William Henney credited the Workingmen's Fund with making the 1905

the understanding that one shall be placed upon the bench of each workman and workwoman; subsequently they are collected by the superintendent and returned to him." Donations were not deducted from workers' pay, however.

²⁸Board of Directors, Hartford Hospital Minutes, (November 14, 1905), p. 81.

²⁹John F. Gunshanan Obituary, Hartford Times, August 5, 1930, p. 20.

reopening of the sanatorium possible: "These workingmen got a fund together and got that sanitarium [sic.] opened and sent men there from all over the city...."³⁰ Financial data given in Hartford Hospital's annual report of 1907 supports Henney's contention: Between 1905 (when Wildwood reopened) and 1907, the state contributed \$15,000, the Workingmen's fund \$13,158.50, the city of Hartford \$11,408.64 and paying patients \$10,403.40.³¹ Thus, between 1905 and 1907 Gunshanan's fund paid for more patients than did the city of Hartford.

This is not to say that the money provided by the Workingmen's Fund was sufficient; the same annual report notes that for every \$7.00 paid by the Fund the hospital contributed \$5.00 -- a situation with which the hospital was not happy.³² The inadequacy of the resources provided by workingmen to meet the needs of their fellows at Wildwood is clear from Hartford Hospital's annual reports. Although the relationship had begun well, with a glowing expression of appreciation of the "Working Man's Fund" in 1905,³³ by 1907, the unpleasant reality was clear:

It is obvious from the account rendered, however much we may sympathize with and desire to encourage the meritorious self-respecting and generous effort of the workingmen to give protection, support and ... care to their unfortunates who have contracted Tuberculosis [sic.], we

³⁰General Assembly of the State of Connecticut, Public Hearings before the Joint Standing Committee on Humane Institutions [stenographer's notes], (January session 1911), p. 39.

³¹Hartford Hospital Annual Report, 1907, p. 23.

³²Ibid.

³³Hartford Hospital Annual Report, 1905, p. 19.

are not justified in continuing to extend to them the financial credit and assistance we have contributed since March 1st. [There follows a financial summary showing Hartford Hospital's deficit in running Wildwood.] The beneficiaries of the Workingmen's Fund have received their proportion of this largesse. For every one of their patients for which they have actually paid seven dollars per week, the Hospital [sic.] has contributed over five....³⁴

This was the final comment by the hospital about money received from the Workingmen's Fund, though in 1908 and 1909 the Fund appeared as a line item under contributions.³⁵ As noted above, Cedarcrest opened in 1910 and Wildwood patients who were supported by public funds were sent there -- presumably this included those who had been recipients of the free beds of the Workingmen's fund.

JOHN GUNSHANAN AND THE TUBERCULOSIS COMMISSION

In 1907, Governor Woodruff, a Republican, appointed a special ten-man commission³⁶ to investigate the tuberculosis problem. The chair, Dr. Foster, had been executive director of Gaylord

³⁴Hartford Hospital Annual Report, 1907, p. 23. It should be noted that \$7.00 per week was the usual patient fee for Wildwood.

³⁵The sum, \$2,085.80, was the same both years. Either there was a very large amount of money on deposit and this represents the income (unlikely though possible), or an error was made and the 1909 entry was copied direct from that of 1908. I tend to the latter view, and suspect that no funds were supplied in 1909.

³⁶In addition to Gunshanan, they were: John P.C. Foster, MD (chair, from New Haven), William J. Brennan (New London), Horace B. Cheney (Manchester), Albert P. Dossin (Meriden), Charles E. Julin (secretary, no town listed), Arthur R. Kimball (Waterbury), Omer La Rue, MD (Putnam), Stephen J. Maher, MD (New Haven), Rev. James B. Nihill (Bridgeport). Report of Special Commission to Investigate Tuberculosis, 1908, p. 86.

Sanatorium near New Haven;³⁷ Gunshanan was the only Hartford resident on the commission. The relative lack of Hartford representatives, especially the absence of any physicians from Hartford Hospital, implies either that the Hartford medical community was unwilling to participate in decisions about the treatment of tuberculosis or that Governor Woodruff was not a champion of Wildwood Sanatorium as an example of how to deal with the tuberculosis problem. Suggestive as such political considerations are, the intricacies of the appointment process are lost to the historian, and we cannot know with certainty why the commission was constituted as it was. After the commission's report was accepted, Gunshanan was one of three commissioners (again, the only one from Hartford) appointed to the "Board of Directors to Establish County Homes for the Care and Treatment of Persons Suffering from Tuberculosis"³⁸ empowered to implement the recommendations.

³⁷David Lyman, "The Work of the State Tuberculosis Commission, its Development and Present Outlook," Proceedings of the Connecticut State Medical Society (New Haven: Ct. State Medical Society, 1915), p.196. Foster died in 1910; Lyman implies that the cause of death was tuberculosis.

³⁸The others were George H. Knight, MD, of Lakeville and George E. Hall of New Haven. Hall was replaced by Stephen Maher, MD of New Haven in 1911. Report of Board of Directors to Establish County Homes for the Car and Treatment of Persons Suffering from Tuberculosis (Hartford: State of Connecticut, 1910 and 1912), title pages.

The Tuberculosis Commission issued three substantial reports to the General Assembly between 1907 and 1912;³⁹ the first of these proposed establishing a sanatorium in each county of the state and the last two reported upon implementation. By 1912, sanatoria had been established on the Hartford-Newington city line (Cedarcrest) and in Meriden (Undercliff), Norwich (Uncas-on-Thames), and Shelton (Laurel Heights). There were also plans for a special sea-side facility for the treatment of consumptive children.⁴⁰ Further, legislation was in place which provided mechanisms to approve building sites for future sanatoria and to inspect existing facilities, public and private, along with regulations for the selection, admission and funding of tubercular patients.⁴¹

The evolution of thought about how to provide care for indigent consumptives is apparent both in Gunshanan's work and in the findings of the commission. He must have realized quite soon that mutual benefit organizations, no matter how successful, would not be able to support the number of working class consumptives in

³⁹Report of Special Commission appointed to Investigate Tuberculosis (Hartford: State of Connecticut, 1908); Report of Board of Directors to Establish County Homes for the Care and Treatment of Persons Suffering from Tuberculosis (Hartford: State of Connecticut, 1910); Report of Board of Directors to Establish County Homes for the Care and Treatment of Persons Suffering from Tuberculosis (Hartford: State of Connecticut, 1912.)

⁴⁰It was finally built in 1920, in Niantic and called "Sea-side."

⁴¹These laws evolved between 1907 and 1913. The best summary is "An Act Concerning the State Tuberculosis Commission," Chapter 183, Public Acts of the State of Connecticut (Hartford: State of Connecticut, 1913) p. 1781 - 4.

need, for he lobbied for state assistance for both Wildwood and its counterpart for the New Haven area, Gaylord, in 1907 and 1909.⁴² As he met with workingmen around the state, he must have understood that the extent of the need was greater than he had realized. That broader view of the magnitude of the problem, coupled with disappointment at what workingmen themselves could accomplish, informed his work on the commission.

The commission's findings document the rapidity of the change in the official position about the care of poor consumptives. The state had begun, in 1902, by subsidizing care at Wildwood and Gaylord, small independently operated facilities; in 1907 the commission was appointed; by 1909 its recommendation to establish a system of state-run and funded sanatoria had been accepted. The first of these, Cedarcrest, opened in 1910 to serve the people of Hartford County.

With Cedarcrest's arrival, Wildwood no longer received financial support either from the state or from Gunshanan's Workingmen's Fund. Gunshanan had transferred the focus of his concern for working people with tuberculosis from the private to the public sector. He was a working class progressive reformer.

CONCLUSION -- GUNSHANAN, THE WORKINGMEN'S CLUB AND TUBERCULOSIS

For unknown reasons, when John Gunshanan's term was up in 1913, Governor Baldwin, a Democrat, did not reappoint him, and he did not secure public office again. How Gunshanan supported his

⁴²General Assembly of the State of Connecticut, Hearings Before the Joint Standing Committee on Appropriations [stenographer's notes], (January Session 1907 and January Session 1909).

family before and after his tenure as tuberculosis commissioner is unclear. He may have drawn a salary from the Workingmen's Club, for the city directory called him an "advertising agent" and "promotor, Workingmen's Club" between 1902 and 1908. The Workingmen's Club maintained a reading room on Affleck street until 1915; that there were sufficient funds to rent space suggests that he at least had a base of operations and perhaps also a salary. The club seems to have had a large membership, for when Gunshanan was not reappointed to the Tuberculosis Commission, some 2500 people attended a "testimonial reception" for him.⁴³ Even if Gunshanan was paid by the Club, however, after 1915 the reading room disappeared permanently from the city directory. He was only around 48 years old then, and how he passed the remainder of his life (he died in 1930, age 62) is unknown.

Regardless of how John Gunshanan spent the years after his service as a Tuberculosis Commissioner, for six years in the prime of his life a combination of political influence and commitment to the cause of working class people suffering from tuberculosis provided him with both prestige and a substantial income.⁴⁴ It

⁴³Obituary, Hartford Times, August 5, 1930, p. 20.

⁴⁴Probably \$2500.00 per year. "Act Concerning the State Tuberculosis Commission," p. 1783 gives this amount for 1913. It was unspecified in the earlier acts, but since the 1913 act repeated earlier provisions, I assume the salary had not changed. It was a good sized income for the time: In 1910, his brother Michael was paid \$1350.00 as Investigator for the Board of Charity Commissioners; the Superintendent of the Almshouse received \$2,000.00 annually. [Board of Charity Commissioners Annual Report, 1910, p. 33 - 35.] The physician-superintendent of Hartford Hospital was paid \$2500.00 per year [Hartford Hospital Executive Committee Minutes, January 25, 1909, p. 124.]

is perhaps ironic that the Governors under which he served as commissioner (Woodruff, Lilley and Weeks) were all Republicans and that when a Democrat (Baldwin) was finally elected he was not reappointed. Gunshanan's political roots and power were based locally, in Hartford, however -- Ignatius Sullivan and William Henney were mayors from 1902 to 1908, and it must have been the Hartford machine that was rewarded by his appointment as Tuberculosis Commissioner. He in turn paid his political debts -- Cedarcrest, the first state sanatorium, was built just outside Hartford in 1910. Determining how patronage was channelled through land purchases and building contracts is not part of this paper, but we might expect that an investigation of the construction of Cedarcrest would reveal that partisan obligations were met.

Tracing John Gunshanan's use of the Workingmen's Club to further his political career should not obscure the significance of the financial contributions made by hundreds of people from their factory benches. Indeed, his very success indicates the deeply felt need for a shield against tuberculosis on the part of such contributors. It is also important to note that their attempts collectively to insure themselves for care in the event that they contracted tuberculosis did not imply any ideological commitment to private care. In fact, if John Gunshanan truly represented his constituency, his support for a state-wide system of public sanatoria suggests that what working people, at least in Hartford, wished to avoid was CITY funded, almshouse-based care. Along with him, they must have hoped that the new state facilities

would provide effective, humane treatment for all citizens without the stigma associated with the municipal almshouse.

John Gunshanan and his constituents came to understand that working people, even when they banded together, could not provide the resources necessary to care for the consumptives among them. Since the city had not shown itself willing to move a city hospital out of the stigmatized almshouse, and Hartford Hospital supported its sanatorium reluctantly, the state was the only alternative. Note, however, that Gunshanan accepted the premise that sanatorium care was necessary. He was neither a radical nor a visionary; he did not raise funds to support consumptives in their homes or agitate for higher pay so that workers could afford to be ill or to seek care early. Negotiators and coalition-builders by definition work within the system, and within those limits Gunshanan was effective.

CONCLUSION

...danger-beliefs are as much threats which one man uses to coerce another as dangers which he himself fears to incur by his own lapses from righteousness....¹

Disease, with its seeming randomness, is one aspect of the indeterminable universe that we wish to distance from ourselves. To do so we must construct boundaries between ourselves and those categories of individuals whom we believe [or hope] to be more at risk than ourselves.²

As the quotes above indicate, fear of disease and of the sick is part of the human condition. Tuberculosis must have been a terrifying disease. It killed slowly and unpredictably, but relentlessly. It lurked in the tenements of the poor, where it struck people in what should have been their prime years, sometimes wiping out entire families. Medical professionals and social reformers, already struggling to meet the challenges presented by rapidly increasing numbers of the urban poor, searched for ways to contain the disease. In their anxiety, they sometimes applied such labels as "vicious consumptives,"³ "unteachable"⁴ or "incorrigi-

¹Mary Douglas, Purity and Danger: An Analysis of Concepts of Pollution and Taboo (Great Britain: Pelican Books, 1970), p. 13.

²Sander L. Gilman, Disease and Representation: Images of Illness from Madness to AIDS (Ithaca: Cornell University Press, 1988), p. 4.

³John P.C. Foster, "Detention Institutions for Ignorant and Vicious Consumptives," First Annual Meeting of the Society for the Study and Prevention of Tuberculosis (New York: Irving Press, 1906), pp. 333-8.

ble"⁵ to their patients. Anxiety is also evident in medical preoccupation with labelling the stages of the disease, rhetoric about the need for places in which to house the dangerously advanced cases, and in discussions about which level of government should be responsible for these hopelessly ill patients. Hartford's City Council was reluctant to care for them in either the almshouse or city hospital, and the directors of Hartford Hospital were confronted with a choice between attracting middle class patients and admitting chronic consumptives to the main hospital building. One can read fear in the alacrity with which the Connecticut legislature voted funds for five sanatoria in ten years and even in the melancholy fact that, though patients came reluctantly, sanatorium beds remained full.

Given such apprehension and dread, it is not surprising that sanatoria were embraced as a way to separate at least some of the most dangerous ill from the well. Even if social science research had been sophisticated enough to reveal how ineffective sanatoria were at achieving cures, it is doubtful that anyone would have listened. Hartford's powerful players in the development of public policy all had reasons for desiring a place in the country for the tubercular poor: Physicians and hospital administrators wanted to

⁴Ellen LaMotte, "The Unteachable Consumptive," Transactions of the Sixth International Congress on Tuberculosis (Philadelphia: William F. Fell Co., 1908), pp. 256-60.

⁵E. O. Otis, et. al., "How may the best results be obtained in the care of the incorrigible consumptive in towns where there are no hospitals?" American Journal of Public Health 4 (December 1914): 1204-8.

free their beds for paying patients, municipal authorities did not want to be forced to fund a city hospital or to enlarge the almshouse, state-level politicians saw that local solutions were inadequate and wanted monuments to their civic concern. The sanatorium, a combination of communicable disease hospital, asylum and poorhouse, was a logical extension of existing medical models. By focusing upon details about where such institutions should be built and which patients belonged in them, politicians and physicians alike reassured the public that the problem of what to do with people with tuberculosis was being addressed.

There were of course patients who needed and benefitted from sanatorium care. Active, open tuberculosis was (and is) highly infectious, and sufferers require care and attention. Despite the loneliness, the spartan living conditions, the work masquerading as therapeutic exercise, for some these country retreats must have provided food and rest that were unavailable in their harried tenement lives. Above all, sanatoria offered what the sick and their families needed most -- hope, and tangible evidence that others recognized their need for care and attention.

I wish to suggest, however, that the presence of sanatoria served more to lull the fears of the uninfected than actually to control the disease. Not even patients who were able to stay three months or more were commonly cured. Nor, apparently, did they die at the sanatoria, but were discharged back into the family and community, infective as ever. As measures to stop the spread of

tuberculosis, sanatoria failed; as mechanisms to allay public anxiety they were more successful.

Although historians are correct to define "social control" as central to an understanding of the progressive reform and institution-building, this paper demonstrates how complex the forces were that dictated the forms institutions would take in specific places. It shows too that policy makers and professionals could change the shape of the institutions they created as they went along; John Gunshanan and his peers were clearly able to respond to the lessons of experience.

A study such as this which considers sanatoria only from the point of view of administrators, physicians and politicians labors under a heavy burden, for it is impossible to test the rhetoric of the times against actual data. What kinds of people were admitted? What were the outcomes when measured by modern statistical methods? How much staff consisted of ex-patients, and what was their bargaining power? How vulnerable were administrators to political pressures and how corrupt were they? The complete story of sanatoria will remain untold until access to sanatorium records, including medical records of patients, enables questions such as those to be answered.

Our understanding of sanatoria in this period is also incomplete because we know almost nothing about attitudes towards tuberculosis and institutionalization, especially among working class and immigrant populations. I have been unable to locate any depiction of the disease in popular culture, not in photographs,

film, paintings, popular songs, stories, or novels (except as a convenient way to remove a character from the action). It appears in newspapers only as dry announcements of medical lectures, the opening of sanatoria, the dangers of spitting -- never as human interest pieces about real people. Not even any middle class memoirs, diaries or accounts of sanatorium life were published. The silence is so great that it demands explanation, and the only way I can interpret it is to posit an almost phobic response -- people did not even want to think about it.

It is fascinating to speculate about the effects of the establishment of a sanatorium system upon the later development of medical care. Had general hospitals had nowhere to send consumptive patients, would they have been slower to develop into efficient providers of acute care? Would today's health care system be better able to manage home care of chronic illness if institutions had not been defined as the optimal locus of treatment eighty years ago? Would we have mechanisms to make medical supervision of home treatment possible or to grant public funds to non-professional care givers or relatives?⁶

Perhaps the most urgent reason to study the sanatorium movement is that now, almost a century after they began to open in large numbers, there are those who believe that sanatoria, or similar institutions, should be reopened.⁷ There have already

⁶Pointed out by Barbara Bates, Bargaining for Life, p. 333.

⁷The question first arose regarding HIV positive patients. See David Rothman and Eileen Tynan, "Advantages and Disadvantages of Special Hospitals for Patients with HIV Infection," New England

been instances in which people with tuberculosis who did not take their medicine have been forcibly hospitalized.⁸ How to ensure that all infected people complete the arduous medical regimen required to treat today's drug-resistant strains of tuberculosis while at the same time respecting their civil rights remains a matter of debate.⁹ Fear is building again. When New York Magazine has two articles about tuberculosis in as many years,¹⁰ when newspaper articles carry headlines such as, "Crowded Jail Cells Breed Fear of Tuberculosis,"¹¹ "Top Scientist Warns Tuberculosis Could Become Major Threat,"¹² and "AIDS Patients, Facing

Journal of Medicine 323 (September 13, 1990): 764 - 8. The authors conclude that disadvantages outweigh advantages.

⁸Josh Barbanel, "Rise in Tuberculosis Forces Review of Dated Methods" New York Times (February 11, 1992), Section B, page 1; Janice Hopkins Tanne, "Q & A about TB," New York Magazine (March 25, 1992): 35.

⁹The current favorite is "directly observed therapy", by which each dose of medication must be witnessed. Michael Specter, "Tougher Measures to Fight TB Urged by New York Panel", New York Times (November 30, 1992), p. 1. The latest medical thinking on the matter may be found in: George J. Annas, "Control of Tuberculosis -- The Law and The Public's Health," New England Journal of Medicine 328 (February 23, 1993): 585-8; Michael Iseman, MD, David Cohn, MD, and John Sbarbaro, MD, "Directly Observed Treatment of Tuberculosis," New England Journal of Medicine 328 (February 23, 1993): 576-8.

¹⁰Tanne, "The Truth About TB" New York Magazine (November 5, 1990): 92 - 5; Tanne, "Q & A About TB."

¹¹Mireya Navarro, New York Times (January 30, 1992) Section B p. 1.

¹²Lawrence K. Altman, New York Times (February 11, 1992), Section C p. 3.

TB, Now Fear Even the Hospital,"¹³ it is clear that people are worried.

It is the historian's task to reveal that the sanatorium on Magic Mountain existed only as a fictional metaphor, and that even Trudeau's famous facility in beautiful Saranac was for paying patients only. The poor and the "advanced" cases were turned away.¹⁴ When we know what sanatoria were really like and what they really accomplished, we will be better able to decide what kinds of institutions, if any, we need to treat tuberculosis today.

¹³Navarro, Sunday New York Times (March 15, 1992), Metro Section, p. 1.

¹⁴Philip L. Gallos, Cure Cottages of Saranac Lake (Saranac Lake: Historic Saranac Lake, 1985), p. 16.

EPILOGUE

As I finished this project, the following paragraph appeared as part of a long article in the Sunday newspaper's magazine section. It sounds depressingly familiar:

Hospitals don't have to be homophobic to want to avoid AIDS patients. Such patients are more likely to be indigent and unable to pay their bills. Also, the knowledge that a hospital has many AIDS patients may drive other patients away.¹⁵

Here are the issues just identified for 1900 - 1910, being presented as somethin new. Rosenberg's observation that perception of disease is both context-specific and context-determining¹⁶ offers the hope that with an understanding of the context, it will be possible to change the perception and hence, perhaps, the context. This has already occurred, in part, in the case of AIDS; the public and private silence so remarkable in the tuberculosis instance was broken early and loudly. Still, the lessons of tuberculosis remain as cautionary tales.

¹⁵Joel Lang, "HIV Positive" Northeast [Magazine section, Hartford Courant], Sunday March 7, 1993, p. 16.

¹⁶Charles E. Rosenberg, "Introduction," in Framing Disease: Studies in Cultural History, eds. Rosenberg and Janet Golden (New Brunswick NJ: Rutgers University Press, 1992), p. xx.

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