Temporarily Detained: Tuberculous Alcoholics in Seattle, 1949 through 1960

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ABSTRACT

Repeatedly noncompliant tuberculosis patients (who are often homeless or substance users) are once again being forcibly detained. Health officials intend that confinement be used only when "less restrictive alternatives" have failed. Past programs of detention can inform current efforts. In 1949, Seattle's Firland Sanatorium established a locked ward. Although initially intended only for active public health threats, the ward was eventually used to maintain order among Firland's alcoholic patients. That is, the staff detained alcoholics—regardless of their infectivity or compliance with medications—for breaking sanatorium rules. In this manner, maintaining institutional order became a legitimate reason for invoking public health powers.

Although new detention regulations strive to protect patients' civil liberties, attention must also be paid to the day-to-day implementation of coercive measures. When public health language is used to justify administrative or institutional requirements, disadvantaged patients may be stigmatized. (*Am J Public Health.* 1996;86:257–265)

Introduction

The recent resurgence of tuberculosis has generated great concern about patients who do not complete their prescribed therapy. Not only do such individuals remain reservoirs of infection, but their erratic compliance has fostered the development of multidrug-resistant strains of tuberculosis.[1] To ensure that noncompliant patients complete their drug treatment, health departments have begun to employ a series of strategies ranging from incentives to involuntary detention. Officials designing such policies have carefully approached the difficult issue of balancing the public's health with the civil liberties of patients.[2]

The use of coercion to prevent the spread of infectious diseases is nothing new. For hundreds of years, health officials have used various forms of quarantine to segregate infectious persons. Although such policies have been designed as public health measures, their actual implementation has been influenced by who is being isolated and who is carrying out the isolation. As a result, quarantine has represented a mechanism for society to control not only infection, but also those who are infected.

Once tuberculosis was definitively shown to be communicable in the late nineteenth century, health departments started to forcibly isolate tuberculous persons that they believed were a danger to the public's health. One of the most ambitious of these programs began in 1948 at Firland, a public sanatorium in Seattle, Washington. Not only did city officials inaugurate a policy of quarantining so-called "recalcitrant" patients at Firland, but they also established a locked ward within the sanatorium for the purpose of involuntary detention.[3]

Officials intended to use the locked ward only for the occasional "bad actor."[4] Yet by 1960, Firland had detained roughly 1000 patients, and the locked ward had become a routine part of the sanatorium care of one group of patients: those alcoholics who frequented a run-down portion of Seattle called Skid Road. As modern officials reinstitute similar policies, it is well worth revisiting Seattle's use of compulsory measures to control the spread of tuberculosis.

Earlier Examples of Quarantine

Although references to the isolation of lepers can be found in the Bible, the term *quarantine* did not appear until the Middle Ages. In that period, quarantine referred to the practice by which officials delayed the landing of ships suspected of carrying victims of the plague or other contagious diseases. Quarantine has since come to mean "the making of a boundary to separate the contaminating from the uncontaminated."[5]

Municipal officials aggressively used quarantine to combat diseases such as cholera well before the discovery of the germ theory of disease in the late 1800s.[6] Yet it was the knowledge that infectious diseases were caused by specific microorganisms transmitted between persons that gave new impetus to the practice of quarantine. Indeed, the scientific imprimatur of the germ theory enabled health

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Note. The views expressed here are the author's and do not necessarily reflect those of the Arnold P. Gold Foundation or the Robert Wood Johnson Foundation.

officials to solidify their authority to determine the appropriate boundaries between the well and the "diseased."[7] During the early twentieth century, state laws routinely granted health departments the power to quarantine individuals with infectious diseases such as diphtheria or typhoid fever.[8]

Although intended for the purpose of preventing the spread of infection, quarantine has traditionally been imposed on "the bodies of those who were least able to protest."[9] On the one hand, this policy made sense, because infectious diseases preferentially affected the poor. The use of quarantine and other compulsory public health measures, however, has also reflected society's tendency to stigmatize and punish those groups that become associated with given diseases.

There are numerous historical examples of this process. For example, health officials incarcerated over 30 000 prostitutes in federally funded institutions during World War I to prevent the spread of venereal disease. Allan Brandt has termed this event "the most concerted attack on civil liberties in the name of public health in American history."[10] Similarly, turn-of-the-century nativist fears that immigrants were vectors of infection led to the arbitrary use of quarantine against specific ethnic and racial groups.[11]

As with health officials selecting persons for quarantine, administrators involved in the day-to-day implementation of enforced isolation have also enjoyed broad authority. Scholarship in this area has focused on what Erving Goffman termed "total institutions." Goffman stressed that facilities such as mental hospitals and prisons, whatever their underlying purpose, ultimately emphasize the "bureaucratic organization of whole blocks of people."[12] Although the expansion of due process after 1960 provided inmates with legal recourse, administrators and staffs of such institutions have had—and continue to have—broad authority to make routine decisions regarding disciplinary and custodial issues. Such management issues would quickly become a primary concern of Seattle officials confining tuberculosis patients.

Confinement for Tuberculosis

Before Robert Koch's 1882 discovery of the tubercle bacillus, most doctors believed that pulmonary tuberculosis, often known as consumption, was not contagious. Rather, they claimed that the disease resulted from a combination of hereditary predisposition and environmental exposures.[13] The use of quarantine became logical, however, once it became clear that tuberculosis was spread when someone inhaled bacilli from an infected person's sputum.

The most aggressive early attempt to isolate infectious tuberculosis patients occurred in 1903 when New York opened a detention facility at Riverside Hospital. The driving force behind this effort was Hermann Biggs, a local health officer and a pioneer in tuberculosis control. Although designed for public health purposes, Riverside also served as a repository for "fractious and intractable" patients, many of whom made the rounds of city hospitals, leaving against medical advice before approved discharge.[14] Biggs's own language bespoke how his policy of forcible detention reflected not only the patients' disease but also the fact that they were usually poor immigrants, vagrants, or alcoholics. "Homeless, friendless, dependent, dissipated and vicious consumptives," he wrote, "are likely to be most dangerous to the community."[15]

Although commentators across the country continued to decry the "careless consumptive," few such patients were detained after 1920.[16] Not only was detention difficult and expensive to administer, but there was often no clear end point: tuberculosis was a chronic disease with no specific cure. In addition, although acknowledged as infectious, tuberculosis never produced the alarm generated by epidemics.[17]

After World War II, however, there was a major nationwide change in philosophy, which Seattle well exemplified. Before the late 1940s, Seattle had not forcibly segregated a single tuberculosis patient, preferring to use its limited funding to treat cooperative patients. In 1948, however, officials instituted a formal quarantine policy. Factors that contributed to the adoption of this new strategy included a general postwar revival of tuberculosis control efforts, the introduction of antibiotics, and growing concern with discharges against medical advice.[18]

As Seattle and Washington underwent major economic development during World War II, funding for tuberculosis control increased markedly. The city also benefited from the 1947 acquisition of a 1350-bed surplus naval hospital that enabled Seattle to house all of its tuberculosis patients for the first time.[19] Named Firland Sanatorium, the facility remained open until 1973.

Another important development occurred in 1946 when Firland became one of the earliest sanatoria to use streptomycin, the first antibiotic effective for tuberculosis. Before this time, the primary therapies for the disease were bed rest and fresh air, supplemented by surgical collapse of the lung.[20] By 1952, two additional drugs, para-aminosalicylic acid and isoniazid, were also available. These drugs enabled doctors to shorten the average hospital stay from 2 years in the early 1940s to 6 months by 1960.[21] Nevertheless, Firland staff believed that the combination of antibiotics, bed rest, and surgery—in a supervised setting—provided the best chance to cure tuberculosis and thus recommended at least 6 months of hospitalization. Patients completed drug therapy as outpatients.

The major obstacle to this strategy, not surprisingly, were discharges against medical advice.[22] Like other sanatoria, Firland had long experienced this problem. Nevertheless, given the new ability to cure patients, the staff grew increasingly frustrated with the idea that partially treated persons might be allowed to infect other Seattle residents.[23] A series of studies performed at Firland, moreover, had revealed that as many as 47% of patients left against advice.[24]

Of particular concern were alcoholics, who, in one study, constituted 74% of all unapproved male discharges.[25] Major changes in the definition of alcoholism had begun to occur in the 1940s as it became conceptualized as a disease rather than a moral transgression.[26] Nevertheless, Firland staff continued to reserve the label for down-and-out winos or tramps, thereby reinforcing stereotypical notions about alcoholism. Evidence of drinking among middle-class patients was basically ignored.[27]

Those Firland patients characterized as alcoholics most often lived on Seattle's Skid Road, a run-down area just south of downtown. (Skid Road appears to have been an earlier version of the term *skid row.*)[28] Due to the marked economic growth experienced by the city during World War II, Seattle had attracted a growing number of transient males, mostly White, who traveled the West Coast and Alaska looking for odd jobs. These men, who were often heavy drinkers, spent much of their time on Skid Road, traveling from bar to flophouse.[29]

Not only did tuberculous Skid Road alcoholics have high rates of discharge against advice, but health officials believed that they were also unlikely to

comply with outpatient therapy. As a result, these officials concluded, such persons often relapsed and were thus likely to spread tuberculosis in the community. In addition, their erratic antibiotic use fostered drug resistance.[30] Both Health Department and Firland staff agreed that a mechanism was needed to ensure that alcoholics remained hospitalized long enough to receive adequate therapy.

Quarantine and Detention in Practice

The first step in such a process, according to Washington State Tuberculosis Control Officer Cedric Northrop, was to clarify existing quarantine regulations. Northrop, who had come to Washington from North Dakota in 1941, had played a crucial role in reviving Seattle's tuberculosis work. An integral part of such efforts, he believed, was to provide health officials with the means to isolate the recalcitrant person with tuberculosis.[31]

In 1948, building on a state law empowering health officers to restrain infectious persons, Northrop drafted two regulations enabling the local health officer to quarantine to Firland any persons with active tuberculosis who were "uncooperative" and "refused to observe the [necessary] precautions to prevent the spread of the disease."[32] Those quarantined were to remain at Firland until approved discharge. Local prosecutors aided Northrop in drafting these regulations, which were subsequently approved by the State Board of Health.

When early efforts at quarantine did not prevent unapproved discharges, Firland established a 27-bed locked ward in June 1949. Known as Ward 6 and located in the old naval brig, the unit was equipped with both locked doors and heavily screened windows. All patients admitted to Ward 6 (most of whom were intoxicated) spent the first 24 hours in one of seven locked cells, which contained only concrete slabs covered by thin mattresses.[33] Although the ward remained locked at all times, the staff let any potentially violent patients leave. In practice, however, such departures occurred infrequently.[34]

Firland staff originally planned to use Ward 6 sparingly. "If coercion is needed frequently," Medical Director Roberts Davies wrote, "it is a sure sign that something is wrong."[35] In fact, the early use of Ward 6 was limited. Northrop observed in December 1949 that the ward housed "only a handful" of patients. There were no beds for women.[36]

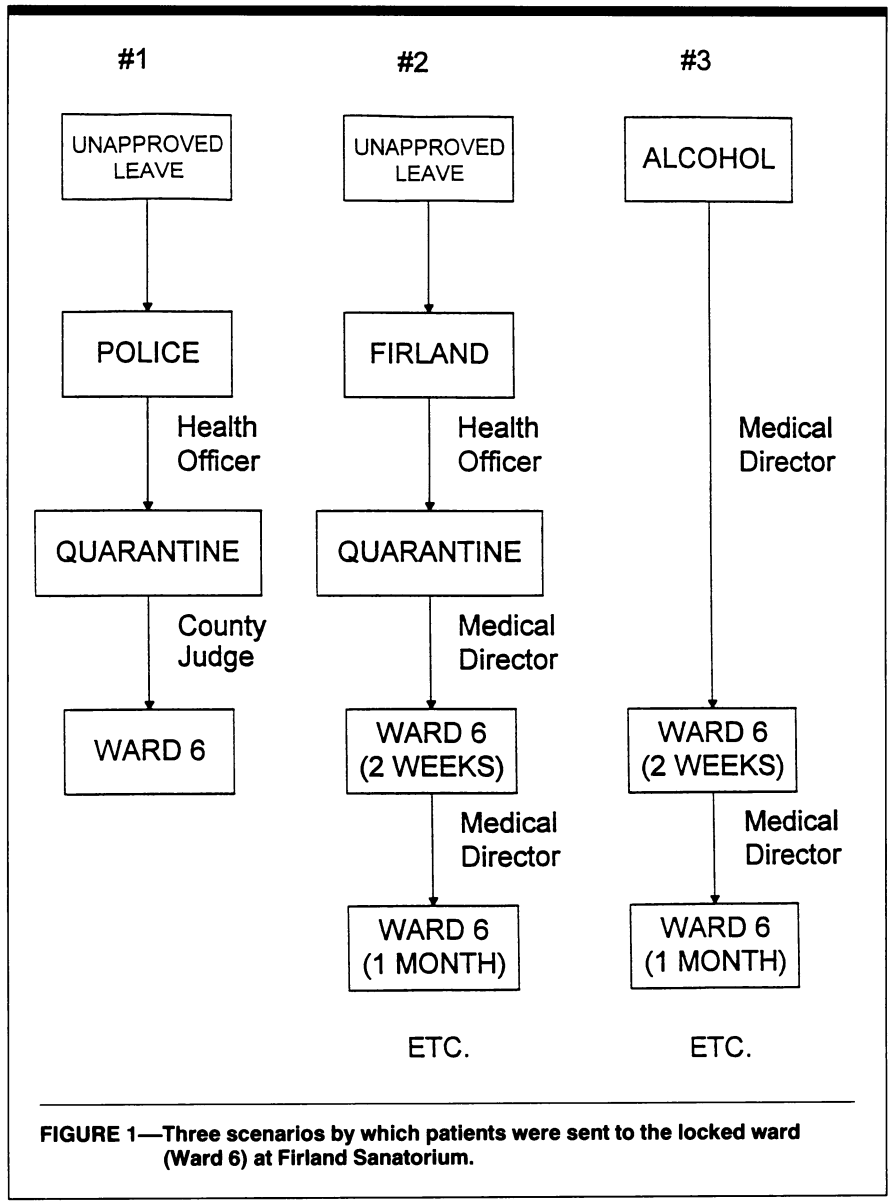
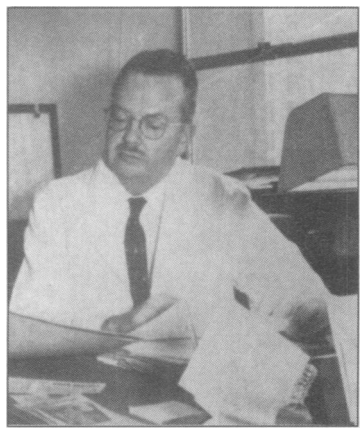


FIGURE 1—Three scenarios by which patients were sent to the locked ward (Ward 6) at Firland Sanatorium.

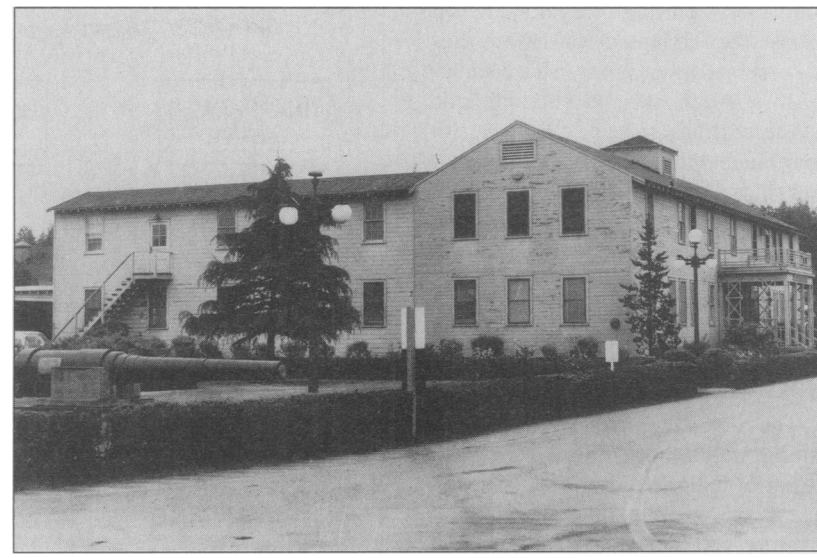
The earliest efforts to employ quarantine and detention focused on patients, generally Skid Road alcoholics, who left the unlocked portion of the sanatorium without permission. Many such patients were quickly found by the police, often when arrested for drunkenness (Figure 1, #1). If there was no past history of recalcitrance, the patient had likely not been on quarantine. In this case, the local health officer quarantined the patient to Firland and returned him to the unlocked portion of the sanatorium. (Jail sentences for drunkenness were suspended.)[37]

If a patient was already on quarantine, however, he was guilty of an actual offense: violation of quarantine. In this situation, a King County judge sentenced the individual to the locked ward. A formula established by Firland determined how long patients remained on Ward 6 before returning to the unlocked portion of the sanatorium: the first stay was 2 weeks, the second was 1 month, and the third was 2 months.[38]

Frequently, patients who had left the sanatorium without permission returned by themselves, often after drinking sprees. Many had overstayed 24- or 48-hour passes. When these patients returned to Firland, they too were quarantined and detained (Figure 1, #2). That is, the health officer quarantined to Firland those patients without previous offenses and sent those already on quarantine to Ward 6. In these cases, however, detention bypassed the formal legal system.[39] The medical director directly sent patients to Ward 6, the duration of the stay again depending on whether they had



Washington State health officer Cedric Northrop, whose plan for reviving tuberculosis control in Seattle included the use of detention.



The Administration Building at Firland Sanatorium, circa 1960. Photo courtesy of the American Lung Association of Washington.

previously spent time there. This ability to detain patients in Ward 6 without a judge's ruling stemmed from the quarantine order, which read that the patient was to remain "in that section of the Sanatorium designated by the Medical Director."[40]

Northrop's 1948 regulations had specified that only patients with active tuberculosis could be quarantined. This term, however, did not directly correlate with infectiousness. The National Tuberculosis Association defined pulmonary disease as active until there were negative sputum samples and healed x-ray lesions for 6 months.[41] Health officials employed this broad definition of active tuberculosis because healing was a slow process that continued long after the sputum was no longer infectious. Nevertheless, this standard ensured that quarantined and detained patients were often noninfectious.

Yet even if it was reasonable to define active tuberculosis so broadly, sanatorium officials paid little or no attention to whether detained patients actually had active disease. This phenomenon had its major impact beginning in the mid-1950s when Firland adopted an informal policy requiring all alcoholics to remain hospitalized for 12 months, regardless of their medical condition.[42] This 1-year rule was another mechanism to ensure that Skid Roaders received adequate supervised antituberculous therapy. Because officials ignored the criterion of active disease, alcoholics who took unapproved leaves during the last days or weeks of the mandatory 12-month hospitalization—and thus at times had *inactive* tuberculosis—were also sent to the locked ward. Indeed, the staff thought nothing of discharging patients to home directly from Ward 6, a practice that belies the notion that detention was reserved for true public health threats.[43] Clearly, the ward had begun to serve a purpose beyond simply preventing the spread of tuberculosis.

Maintaining Order at Firland

To understand why Firland used public health powers to discipline noninfectious patients, it is important to look at its institutional needs. Because the sanatorium housed hundreds of persons in close quarters for long periods of time, staff members saw "utter chaos" as a persistent possibility; they frequently cited past episodes in which patients had started fires or attempted mass escapes.[44]

Alcohol, in particular, disrupted sanatorium routine. Although a 1947 King County resolution made the "giving or selling of intoxicating liquors" at Firland a misdemeanor,[45] patients who had obtained liquor while on a pass often tossed bottles over the fence and retrieved them once on the inside. "Bootlegger" patients smuggled in large quantities of liquor; loud, raucous drinking parties often followed in the open wards. Such incidents, one doctor claimed, led other patients to request early discharge.[46]

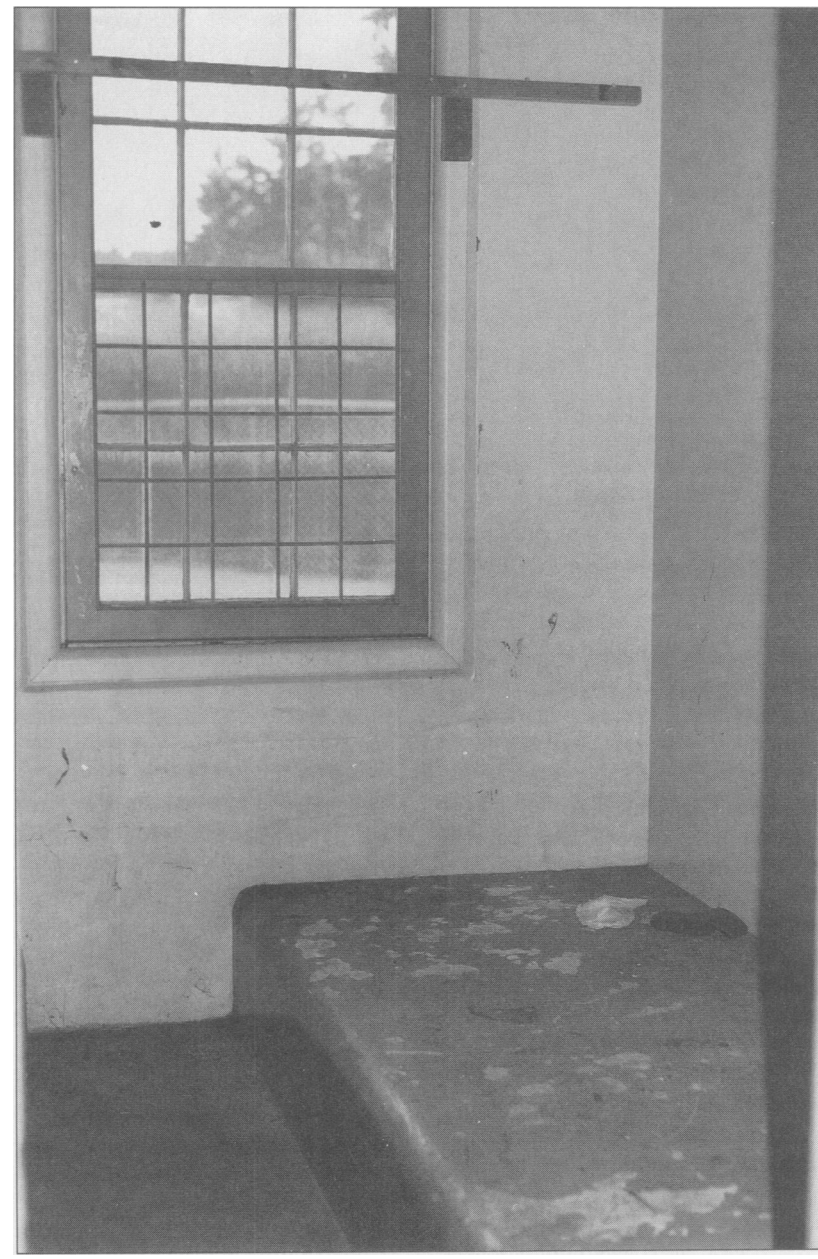
As noted above, patients who left Firland without permission often drank while away and thus were drunk when they returned to the sanatorium. Firland officials justified the detention of such persons—even those with inactive disease—by the need to maintain order. The staff believed that merely allowing such persons, once sober, to return to the regular wards encouraged such behavior. Keeping such persons on the locked ward, conversely, potentially served as a deterrent.[47]

Firland also used this same justification—the need to maintain order—to send to Ward 6 any patients caught drinking or selling alcohol at the sanatorium. This situation is shown in Figure 1, #3. Patients sent to the locked ward for drinking or bootlegging need not have been previously quarantined (although they were subsequently quarantined). Rather, they were sent to the locked ward for having broken the 1947 resolution prohibiting such behavior. Once again, Firland staff handled these cases entirely at the sanatorium without formal legal proceedings.[48] Whether the tuberculosis was active made no difference. Thus, a patient who had never eloped, had complied with his medical therapy, and had been noninfectious for 6 months could be sent to Ward 6 for drinking.

The Firland staff used public health criteria not only to punish patients, but also to reward them.[49] When quarantined patients exhibited both medical improve-

ment and "good behavior," they often qualified for a status of "modified" quarantine.[50] Patients in this latter category were permitted to have short passes away from Firland. Not surprisingly, negotiations often ensued between patients, who requested frequent leaves, and health officials, who feared that such patients were likely to drink while away, bring liquor back to the premises, or not return at all. These fears were well founded. It was not uncommon for Skid Road alcoholics to have four or five stays on Ward 6: many simply committed another infraction shortly after returning to an unlocked ward.

How can we best understand what transpired at Firland in the 1950s? The experience appears to have represented the confluence of two themes discussed earlier: the broad power of twentieth-century health officials to isolate the "diseased" and the ability of total institutions to control their inmates.[51] What is crucial to note in the case of Firland is how these two functions overlapped. Health officials in Seattle originally established policies of quarantine and detention to protect the community from recalcitrant patients with active tuberculosis. Yet the larger goal turned out to be custodial: to keep Skid Road alcoholics institutionalized and reasonably well behaved for 12 months of antibiotic therapy. Once this goal was established, it became necessary to legitimate the disruption of institutional order as a public health violation punishable by quarantine and detention.[52] Given the great disciplinary authority of the medical profession, it is little wonder that Firland successfully blended these public health and institutional imperatives.[53]



One of the locked "cells" used for acutely inebriated tuberculosis patients at Firland Sanatorium, 1949 to 1960. Photo by author, 1993.

Reactions of Patients

As anticipated, Ward 6 housed mostly alcoholics. A 1953 study, for example, found that 88% of locked-ward patients carried the diagnosis of alcoholism.[54] The vast majority of these individuals either lived on or frequented Seattle's Skid Road. Most Ward 6 patients registered no objections. The ward staff was committed to the care of alcoholics and treated them with more tolerance and respect than they received in jail or in public hospitals.[55] In fact, certain locked-ward patients preferred Ward 6 to the unlocked portions of Firland with their constant temptations of alcohol and gambling.[56] By the early 1950s, the sanatorium had also developed an extensive program of social and rehabilitative services. In addition, Firland had hired special staff to address issues of unemployment and alcoholism among Skid Road patients.[57]

Nevertheless, in a series of letters sent to state officials in 1956 and 1957, several patients objected to quarantine and detention procedures. One patient, for example, questioned why the health officer was able to quarantine noninfectious patients. "[C]ontagiousness," she wrote, "has nothing to do with the quarantine. People who have had negative sputum for months may be placed under quarantine."[58]

The same patient also objected to the locked ward. "Ward Six," she stated, "is a jail in every sense of the word; heavily screened windows, locked doors, cells with mattresses on concrite [sic] slabs and restrictions that are to be expected in a regular jail."[59] Others criticized the lack of legal proceedings. The doctors, claimed one patient, "may sentence a patient from one day to six months, as they see fit. We want to know by what right, and on what

Heavily screened windows on the outside of Firland Sanatorium's locked ward. Photo by author, 1993.

authority this is being done."[60] Patient dissatisfaction culminated when a former Firland employee collected 51 pages of "patients' grievances," which he sent to the governor.[61]

These complaints were generally greeted with skepticism or hostility. Health officials were particularly critical, terming the missives "typical 'crank' letters which we have been accustomed to seeing produced by the paranoid type of personality."[62] Eventually, however, the patients' complaints reached the Washington State chapter of the American Civil Liberties Union. American Civil Liberties Union members who investigated conditions at the sanatorium in 1957 generally confirmed the allegations: Firland used quarantine as punishment and incarcerated patients on Ward 6 without due process. Yet after pointing out these problems to the Firland staff, the union let the issue drop.[63]

Indeed, by the end of the 1950s, the use of quarantine and detention at Firland had become formally institutionalized. In 1959 the staff drafted an 18-page document that codified the policies described above.[64] Meanwhile, the use of quarantine and detention at Firland rose, reflecting the fact that tuberculosis was increasingly becoming a disease of the poorest members of society, such as Skid Road alcoholics.[65] Whereas 10% of patients had been quarantined in 1952, the figure reached 30% by 1960.[66] In 1954, Ward 6 expanded from 27 to 54 beds, including 6 beds for women.[67] By 1960, Washington State had detained approximately 1000 patients.[68] The vast majority of these were held at Firland. Detention, initially meant for the occasional recalcitrant individual, had become standard management of the Skid Road alcoholic patient.

Detention across the Country

Seattle's increased use of compulsory public health powers after World War II epitomized developments across the United States. Between 1948 and 1955, 22 states passed new laws regarding the isolation of recalcitrant tuberculosis patients. By 1960, 31 states employed some type of compulsory hospitalization. Detention policies varied greatly. For example, although certain states required extensive legal proceedings, including the provision of lawyers to potential detainees, others did not. Most health departments kept patients in locked hospital wards, although three states and three cities used actual prison facilities.[69]

Although detention protocols differed widely, Seattle's system served as a model for the country. Northrop and Firland staff published several articles describing the "practical management of the recalcitrant tuberculosis patient."[70] Numerous health officials from across the United States visited Ward 6. Not surprisingly, policies similar to those at Firland existed elsewhere. For example, other states detained noncompliant patients who had violated sanatorium rules.[71] As patients in several states were confined for 6 to 12 months, many of these persons likely also had inactive tuberculosis or had been noninfectious for several months.[72]

The vast majority of tuberculosis workers in the 1950s advocated some use of detention. A 1958 editorial in the *Journal of the American Medical Association,* while noting the controversial nature of enforced isolation, agreed that for persistently obstinate patients it was necessary to "resort to available legal measures."[73] Nevertheless, a few commentators decried detention altogether, terming it a "misapplication of police authority" that led health officials to treat patients like criminals.[74]

Conclusion

Seattle health officials designing a plan to confine uncooperative tuberculosis patients drew on a long tradition permitting the isolation of contagious persons to protect the community. Yet those implementing the new policies of quarantine and detention saw their goal as larger than simply segregating infectious persons. The availability of antibiotic agents raised the hope that, for the first time, recalcitrant tuberculosis patients could be cured of their disease once and for all. In Seattle, the individuals that caused the most concern were Skid Road alcoholics.

Thus, health officials and the staff of Firland Sanatorium instituted an informal policy that kept all Skid Road alcoholics hospitalized for 12 months of supervised antibiotic therapy, roughly 6 months longer than the average stay. Alcoholics at Firland were thus "temporarily detained" with the hope of effecting permanent cures. Implementation of this plan, however, required sanatorium staff to address custodial issues such as unapproved leaves and drinking in the unlocked portion of Firland. To discourage or punish such behavior, the staff used the public health powers of quarantine and detention. As a result, whether patients were infectious, had active tuberculosis, or had been noncompliant with their medications was often irrelevant. Maintenance of order at the institution had itself become a legitimate reason for invoking public health powers.

Firland initially planned to use quarantine and detention for the occasional bad actor, as only one portion of a comprehensive program to address the multiple sociomedical problems of alcoholic patients. By 1960, however, quarantine and detention had become a routine part of the care of Skid Road alcoholics. Most decisions regarding confinement were made at the sanatorium by the medical director and his staff. In deference to the authority of public health and medicine, the local legal community gave its full approval. Even the American Civil Liberties Union scarcely objected. It was not until 1964 that growing concern with due process led a local judge to come to Firland to hear patients' complaints.[75]

Due process issues have become paramount as modern officials fighting the resurgence of tuberculosis establish policies and facilities for the detention of noncompliant patients.[76] Drawing heavily on legislation regarding the confinement of mentally ill patients, these officials are fashioning much more sophisticated laws and regulations that respect patients' civil liberties.[77] First, civil commitment and confinement can occur only if a given individual represents a "significant risk" to the public. Second, this person must receive full due process of law, including a prompt hearing and provision of counsel. Finally, before requesting commitment proceedings, health officials must employ "less restrictive alternatives" to improve patient compliance with outpatient antibiotic therapy.[78] These include addressing patients' psychosocial problems, establishing flexible clinic hours, using inducements such as meals or subway tokens to improve clinic attendance, and, most notably, instituting directly observed therapy.[79] In directly observed therapy programs, outreach workers observe patients take their daily or twice-weekly medications, either in the clinic or other locations—such as apartments or park benches—that are most conducive to compliance.[80]

What does the Seattle experience teach us? Clearly, much has changed since the 1950s. Today's uncooperative tuberculosis patients are not exclusively alcoholics, nor are most patients institutionalized for prolonged periods. Drug resistance, formerly a minor concern, has become a major problem. Despite these differences, however, the historical record reminds us of three important points.

First, drafting more elaborate laws and regulations has never prevented the possible misuse of authority by those carrying out public health policies. Although acting in an era before the due process revolution, officials in Seattle nevertheless attempted to delineate—and limit—the power of the health officer to confine the uncooperative patient. In practice, however, the broad authority of those implementing quarantine and detention permitted the established limits to be stretched. Thus, even as they comply with the letter of the law, modern administrators must also avoid the use of unwarranted coercion in the day-to-day operation of programs such as directly observed therapy. Such a goal requires both the solicitation of feedback from patients and constant reexamination of the system.[81] These safeguards will be particularly important if declining rates of tuberculosis shift attention and funding away from control programs.

Second, public health officials should employ coercion, when necessary, based on the actual likelihood that an individual is at risk for spreading infection—not based on any category to which that individual belongs. In Seattle, the label "Skid Road alcoholic" meant a 12-month sanatorium stay, based on a presumption that such individuals were likely to be noncompliant. Today's "difficult" tuberculosis patients are also likely to have multiple sociomedical problems, including homelessness, substance use, and psychiatric disease. Moreover, they are likely to belong to groups more prone to be stigmatized, such as the poor, minorities, immigrants, and persons with human immunodeficiency virus infection. Selection of patients for directly observed therapy, which is carried out by health officials without formal legal proceedings, should not reflect our preconceived notions about compliance in such groups.[82] Nor, more importantly, should recent reports touting the efficacy of directly observed therapy[83] discourage efforts—such as providing apartments for the homeless or rehabilitation for drug users—that address the underlying causes of noncompliance.

Third, for patients detained in inpatient facilities, officials must not confuse custodial or management issues with public health goals. At Firland, bad behavior led to detention, and good behavior led to relaxation of quarantine. Although the use of punishments and privileges will continue in total institutions, such institutional exigencies must not co-opt the actual purpose of the forced isolation.[84] Thus, drinking alcohol or breaking other rules should not necessarily result in longer detention for public health purposes; conversely, good behavior may not signify that earlier release is appropriate. Avoiding the conflation of institutional and public health goals requires not only acknowledging that such conflicts exist, but also determining how responsibility for discipline, treatment, and detention should be allotted among health officials, institutional staff, and the courts.

Throughout this century, tuberculosis workers have struggled with the difficult task of balancing patients' liberties with the protection of the public's health. If they have erred at times on the side of coercion, they have done so with broad societal approval. Although modern laws and regulations represent a more sophisticated approach to the uncooperative tuberculosis patient, we must closely examine how these new policies are implemented. □

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sional Language: Words That Succeed," *Radical History Review* 34 (1986): 33–51; James A. Trostle, "Medical Compliance as an Ideology," *Social Science and Medicine* 27 (1988): 1299–1308. This type of analysis likely applies to the events described in this article. That is, health officials' use of the pejorative term *recalcitrant* to describe alcoholics who disregarded treatment recommendations likely encouraged the adoption of a particularly coercive approach to this population. Having stated this caveat, I will continue to use the terminology employed during the 1950s.

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8. Rogers, *Dirt and Disease,* 30–44; Edgar A. Jonas, "Law Enforcement in the Control of Tuberculosis," *American Journal of Public Health* 13 (1923): 113–118; Stuart Galishoff, *Safeguarding the Public Health. Newark, 1895–1918* (Westport, Conn: Greenwood Press, 1975), 29–34. The most infamous case of enforced isolation is probably that of Typhoid Mary. See Judith W. Leavitt, " 'Typhoid Mary' Strikes Back. Bacteriological Theory and Practice in Early Twentieth-Century Public Health," *Isis* 83 (1992): 608–629.
9. Dorothy Porter and Roy Porter, "The Enforcement of Health: The British Debate," in *AIDS. The Burdens of History,* ed. Elizabeth Fee and Daniel M. Fox (Berkeley, Calif: University of California Press, 1986), 107.
10. Allan M. Brandt, "AIDS: From Social History to Social Policy," in *AIDS. The Burdens of History,* ed. Elizabeth Fee and Daniel M. Fox (Berkeley, Calif: University of California Press, 1986), 151.
11. Musto, "Quarantine," 109–112; Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York, NY: Basic Books, 1994); Howard Markel, "Layers of Separation: Epidemics and the Quarantining of East European Jewish Immigrants in New York City During the Late 19th Century" (Ph.D. diss, Johns Hopkins University, 1994).
12. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, NY: Anchor Books, 1961), 6. See also David J. Rothman, *Conscience and Convenience. The Asylum and Its Alternatives in Progressive America* (Boston, Mass: Little, Brown, 1980), 324–421; Elizabeth Lunbeck, *The Psychiatric Persuasion. Knowledge, Gender, and Power in Modern America* (Princeton, NJ: Princeton University Press, 1994). Lunbeck has built on the work of Michel Foucault, as documented in *Discipline and Punish: The Birth of the Prison* (New York, NY: Pantheon Books, 1977).
13. Henry I. Bowditch, "Consumption in America," in *From Consumption to Tuberculosis. A Documentary History,* ed. Barbara G. Rosenkrantz (New York, NY: Garland Publishing, 1994), 57–96. First published in the *Atlantic Monthly* (January–March 1869).
14. Michael E. Teller, *The Tuberculosis Movement. A Public Health Campaign in the Progressive Era* (New York, NY: Greenwood Press, 1988), 93, 94; David F. Musto, "Popular and Public Health Responses to Tuberculosis in America after 1870," in *AIDS and the Historian,* ed. Victoria A. Harden and Guenter B. Risse (Washington, DC: US Department of Health and Human Services, 1991), 14–20; Sheila M. Rothman, *Living in the Shadow of Death. Tuberculosis and the Social Experience of Illness in American History* (New York, NY: Basic Books, 1994), 191–193. On Biggs's outstanding work in tuberculosis control, see Charles E-A. Winslow, *The Life of Hermann Biggs, M.D., D.Sc., LL.D.: Physician and Statesman of the Public Health* (Philadelphia, Pa: Lea & Febiger, 1929).
15. Musto, "Popular and Public Health Responses," 17.
16. Musto, "Quarantine," 107. One exception was California, which began a program of detention in 1931.
17. Barron H. Lerner, "New York City's Tuberculosis Control Efforts. The Historical Limitations of the 'War on Consumption.' " *American Journal of Public Health* 83 (1993): 758–76[illegible] Although detention was infrequent during this era, public sanatoria were [illegible]ously strict. Control of daily activities was seen as crucial to "chasing the cure."
18. Recent memories of World War II undoubtedly contributed to the rejuvenation of the "war on tuberculosis" in Seattle and across the country. For an insightful analysis of how military language and metaphors have permeated tuberculosis control, see JoAnne Brown, "Playing the Game: Tuberculosis, Medievalist Nostalgia, and the Great War" (paper presented at the Organization of American Historians, Atlanta, Ga, April 1994). As we shall see, Seattle's "new" sanatorium in 1947 was an old naval hospital, and detention of patients occurred in the former naval brig.
19. Marcelle Dunning and Robert Heskett, "Diseases Through the Century: Public Health Becomes Involved," in *Saddlebags to Scanners. The First 100 Years of Medicine in Washington State,* ed. Nancy Rockafellar and James W. Haviland (Seattle, Wash: Washington State Medical Association, 1989), 133–154.
20. The history of preantibiotic therapeutics is actually much more complex and includes the use of alternative remedies and nostrums. See, for example, Linda Bryder, *Below the Magic Mountain. A Social History of Tuberculosis in Twentieth-Century Britain* (Oxford, England: Clarendon Press, 1988), 157–198. For the triumphant story of the discovery of antibiotics, see Frank Ryan, *The Forgotten Plague. How the Battle Against Tuberculosis Was Won—and Lost* (Boston, Mass: Little, Brown, 1993).
21. *Annual Report,* Firland Sanatorium, 1960, p. 12.
22. William B. Tollen, "Irregular Discharge: The Problem of Hospitalization of the Tuberculous," *Public Health Reports* 63 (1948): 1441–1473; Godias J. Drolet and Donald E. Porter, *A Study of "Why Do Patients in Tuberculosis Hospitals Leave Against Medical Advice"* (New York, NY: New York Tuberculosis and Health Association, 1949).
23. The discovery of antibiotics did not automatically change longstanding notions about the chronicity or incurability of tuberculosis. In this light, it is not surprising that a concept such as compliance with one's antibiotic therapy may have remained foreign to many patients and that discharges against medical advice persisted.
24. Cedric Northrop et al. "The Practical Management of the Recalcitrant Tuberculous Patient," *Public Health Reports* 67 (1952): 894–898; Barbara Dike, "A Study of Clinical Records to Determine Some of the Factors Involved in Irregular Discharges of Ninety-Four Patients Who Left Firland Sanatorium Against Medical Advice During the Period of January 1, 1950 to June 30, 1950" (master's thesis, University of Washington, 1953), 58–63; Evelyn N. Hadaway, "A Medical Social Study of Fifty-Four Tuberculosis Patients Who Left Firland Sanatorium Against Medical Advice in 1952" (master's thesis, University of Washington, 1953), 52–57.
25. Hadaway, "Medical Social Study," 32.
26. There is a large literature on changing concepts of alcoholism after the repeal of Prohibition. See Elvin M. Jellinek, *The Disease Concept of Alcoholism* (Piscataway, NJ: Alcohol Research Documentation, 1960); Ronald Roizen, "The American Discovery of Alcoholism, 1933–1939" (Ph.D. diss, University of California at Berkeley, 1991).
27. Interview with Firland Sanatorium sociologist Joan K. Jackson, December 5, 1992. Firland physicians generally only labeled as alcoholic those Skid Road patients who admitted to extensive past drinking or who drank on the premises.
28. Skid Road earned its name because loggers dragging lumber to the Seattle waterfront greased the road so that the logs would skid. Skid Road later referred to the area south of the original pathway.
29. On the Skid Road alcoholic in Seattle, see Joan K. Jackson and Ralph Connor, "The Skid Road Alcoholic," *Quarterly Journal of Studies on Alcohol* 14 (1953): 468–486; James P. Spradley, *You Owe Yourself a Drunk: An Ethnography of Urban Nomads* (Boston, Mass: Little, Brown, 1970). There was also a large population of Native Americans on Seattle's Skid Road, whose experiences at Firland I will explore in future work.
30. Dike, "Clinical Records," 61; *Annual Report,* Firland Sanatorium, 1950, pp. 6–8; Daniel Widelock et al., "Public Health Significance of Tubercle Bacilli Resistant to Isoniazid," *American Journal of Public Health* 45 (1955): 79–83.
31. Northrop, "Practical Management," 895.

32. Ibid., 895, 896.
33. Ibid., 894–898; Roberts Davies, "Isolating the Recalcitrants," *Bulletin of the National Tuberculosis Association* 10 (1954): 121, 122; Mark A. Linell, "The Detention Ward and Its Place in the Control and Treatment of Tuberculosis," *American Review of Tuberculosis and Pulmonary Diseases* 74 (1956): 410–416.
34. Linell, "Detention Ward," 411.
35. Roberts J. Davies, "The Prerequisites for a Successful Campaign of Tuberculosis Eradication," *Health Pilot* 29 (1947): 6–8, 11.
36. *Annual Report,* Washington State Department of Health, 1949, p. 9.
37. Northrop, "Practical Management," 895, 896; Interview with Firland Sanatorium staff physician Walter T. Miller, October 19, 1992.
38. Davies, "Isolating the Recalcitrants," 121, 122; Linell, "Detention Ward," 411.
39. Miller interview, October 19, 1992.
40. Notices of Quarantine. Health Department Administrative Files, WSA, box 6, folder: tuberculosis control, 1953–54.
41. *Diagnostic Standards and Classification of Tuberculosis* (New York: National Tuberculosis Association, 1950), 36, 37.
42. Linell, "Detention Ward," 415.
43. Ibid., 411.
44. Davies, "Isolating the Recalcitrants," 121. Quoted phrase is from Miller interview, October 19, 1992.
45. Resolution 10289, January 6, 1947, King County Commissioners, King County Archives, Seattle, Washington, box 29.
46. Linell, "Detention Ward," 411; "Doctor's Report. Only 20 Per Cent at Firland Diagnosed as Alcoholics," *Seattle Times,* 2 September 1960, p. 6.
47. Linell, "Detention Ward," 415.
48. Northrop, "Practical Management," 896; Miller interview, October 19, 1992.
49. For a similar discussion of punishments and privileges, see Goffman, *Asylums,* 51–53; Julius A. Roth, *Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers* (Indianapolis, Ind: Bobbs-Merrill, 1963), 52–56.
50. Notices of Quarantine. Health Department Administrative Files, WSA, box 6, folder: tuberculosis control, 1953–54.
51. Others have characterized tuberculosis sanatoria as "total institutions." See Goffman, *Asylums,* 4; Rothman, *Living in the Shadow,* 227; Bryder, *Below the Magic Mountain,* 200–214.
52. Goffman uses the term *rationalization* to describe the process by which institutional policies are justified on other grounds. See *Asylums,* 46, 47.
53. On the disciplinary authority of the medical profession, see Lunbeck, *Psychiatric Persuasion,* 81–96.
54. Linell, "Detention Ward," 413.
55. Jackson interview, December 5, 1992.
56. Davies, "Isolating the Recalcitrants," 122; Interview with Firland Sanatorium staff physician Helen S. Marshall, September 2, 1992.
57. Northrop, "Practical Management," 896; Emily B. Fergus and Joan K. Jackson, "The Tuberculous Alcoholic Before and During Hospitalization" (editorial), *American Review of Tuberculosis and Pulmonary Diseases* 79 (1959): 659–661.
58. D.H. to Governor Albert Rosellini, January 21, 1957. State Department of Health, Director's Files, 1954–57, WSA, box 1, folder: 59.
59. Ibid.
60. A.P. to To Whom it May Concern (no date). American Civil Liberties Union of Washington papers, University of Washington Archives, Seattle, Washington (hereafter referred to as ACLU-W), box 25, folder: due process committee, Firland Sanatorium.
61. Harvey Hurtt to Governor Albert Rosellini, March 28, 1957. State Department of Health, Director's Files, 1954–57, WSA, box 2, folder: 86.1.
62. Washington State Department of Health, "Objectives of Tuberculosis Hospital Survey Team, March 21, 1957." Department of Social and Health Services 300 Files, WSA, box 42, folder: consolidation (history).
63. Minutes of the Board of Directors, February 7, 1957, and December 5, 1957. ACLU-W papers, box 15, folder: 1957.
64. Byron F. Francis, "Policies Covering the Operation of the Detention Ward at Firland Sanatorium, 1960." Department of Social and Health Services 300 Files, WSA, box 40, folder: Firland (1968).
65. Lerner, "New York City's Tuberculosis Control Efforts," 672.
66. Northrop, "Practical Management," 898; "Doctor's Report," 6.
67. Davies, "Isolating the Recalcitrants," 121.
68. "Compulsory Isolation—Its Ingredients. New Mexico Reports on Questionnaire Survey," *National Tuberculosis Association Rehabilitation Events,* 6, no. 1 (1960): 1, 2.
69. Ibid., 1; National Tuberculosis Association, "Report on Compulsory Isolation in the United States, December 1955," American Lung Association Archives, New York, NY, folder: 2708.
70. Northrop, "Practical Management," 894–898; Davies, "Isolating the Recalcitrants," 121, 122; Linell, "Detention Ward," 410–416; Cedric Northrop, "Compulsory Isolation," *Bulletin of the National Tuberculosis Association* 42 (1956): 149–150.
71. Andrew L. Banyai and Anthony V. Cadden, "Compulsory Hospitalization of Open Cases of Tuberculosis," *American Review of Tuberculosis* 50 (1944): 136–146; Robert L. Kennedy, "Recalcitrant Patients," *Bulletin of the National Tuberculosis Association* 43 (1957): 55, 56.
72. Edward Kupka and Marion R. King, "Enforced Legal Isolation of Tuberculous Patients," *Public Health Reports* 69 (1954): 351–359; Stuart Willis, "The Case for Forcible Hospitalization of the Recalcitrant Tuberculosis Patient, *Rhode Island Medical Journal* 42 (1959): 650, 652, 654, 655.
73. "The Recalcitrant Tuberculosis Patient" (editorial). *Journal of the American Medical Association* 167 (1958): 74.
74. Sidney H. Dressler, "The Case Against Compulsory Isolation of the Recalcitrant Tuberculous," *Rhode Island Medical Journal* 42 (1959): 651, 653.
75. Regarding the rise of due process, see David J. Bodenhamer, *Fair Trial. Rights of the Accused in American History* (New York, NY: Oxford University Press, 1992), 113–125. I will discuss events in the 1960s in subsequent work.
76. Sue Etkind et al., "Treating Hard-to-Treat Patients in Massachusetts," *Seminars in Respiratory Infections* 6 (1991): 273–282; Mireya Navarro, "Confining Tuberculosis Patients: Weighing Rights vs. Health Risks, *New York Times,* 21 November 1993, pp. 1, 45; Donna Leusner, "State Drawing Plans to Quarantine Uncooperative Tuberculosis Patients," *Star-Ledger* (Newark, NJ), 28 April 1994, p. 14; "Quarantine Center Proposed for Recalcitrant Tuberculosis Patients," *San Francisco Chronicle,* 14 June 1994, p. 17.
77. See reference 2.
78. A debate has arisen over what constitutes "less restrictive alternatives." See, for example, New York City Tuberculosis Working Group, "Developing a System for Tuberculosis Prevention and Care in New York City," in *The Tuberculosis Revival—Individual Rights and Societal Obligation in a Time of AIDS* (New York, NY: United Hospital Fund, 1992), 51–58; Ronald Bayer and Laurence Dupuis, "Ethical and Legal Issues in Tuberculosis Control," *Annual Review of Public Health* 16 (1995): 307–326.
79. Dubler et al., "Tuberculosis in the 1990s," 22–25; Mindy T. Fullilove et al., "Psychosocial Issues in the Management of Tuberculosis," *Journal of Law, Medicine & Ethics* 21 (1993): 324–331.
80. Michael D. Iseman et al., "Directly Observed Treatment of Tuberculosis. We Can't Afford Not to Try It," *New England Journal of Medicine* 328 (1993): 576–578.
81. For a similar discussion, see Nancy N. Dubler, "Jail and Prison Health Care Standards," in *In Search of Equity. Health Needs and the Health Care System,* ed., Ronald Bayer et al. (New York, NY: Plenum Press, 1983), 69–94.
82. Trostle, "Medical Compliance," 1299–1308.
83. Stephen E. Weis et al., "The Effect of Directly Observed Therapy on the Rates of Drug Resistance and Relapse in Tuberculosis," *New England Journal of Medicine* 330 (1994): 1179–1184.
84. The "co-opting" of medical goals within a prison setting is discussed in Dubler, "Jail and Prison Health Care Standards," and Nancy N. Dubler and B. Jaye Anno, "Ethical Considerations and Interface with Custody," in *Prison Health Care: Guidelines for the Management of An Adequate Delivery System,* ed. B. Jaye Anno (Washington, DC: U.S. Department of Justice, 1991), 53–69. For a recent example of custodial problems at a detention center for tuberculosis patients, see Mireya Navarro, "Four Patients at TB Center are Arrested in Attack," *New York Times,* 27 January 1994, p. B8.