Taking the Cure to the Poor: Patients' Responses to New York City's Tuberculosis Program, 1894 to 1918

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ABSTRACT

Drawing on the case files of a major charitable agency, this paper explores how poor people experienced New York City's pioneering program of tuberculosis control. Although the program provided enormous benefits, poor New Yorkers often had pressing concerns that took priority over eradicating tuberculosis. Moreover, the program imposed extreme hardships even as it promised liberation from a terrible scourge. Poor people did not protest collectively, but many individually resisted. They delayed seeking diagnosis, disobeyed the advice promulgated by the Department of Health, attended clinics irregularly, and either refused to enroll in hospitals, sanatoria, and preventoria or fled soon after arrival. (*Am J Public Health.* 1997; 87:1808–1815)

Despite the recent flowering of US public health history, we know little about the perspective of targeted populations. Most historians rely heavily on the records of health officials, analyzing their beliefs, goals, and activities. Scholars evaluate the efficacy of public health interventions in reducing mortality, not the overall impact of such interventions on poor people's lives. Investigations of the responses of various groups tend to focus only on those rare moments when collective protests erupted.[1] This paper seeks to complement the "top-down" approach. Drawing on the case files of the New York Charity Organization Society (COS) between 1894 and 1918, it explores how poor people experienced New York City's pioneering program of tuberculosis control.[2]

Poor New Yorkers had good reason to embrace the tuberculosis campaign. A chronic disease, tuberculosis inflicted years of disability before causing death. Although the disease affected the entire population during the 19th century, after 1900 it was concentrated among poor people, especially immigrants and people of color.[3] Tuberculosis also forced many low-income people into poverty.[4] Nevertheless, poor people often had pressing concerns that took priority over eradicating the disease. Moreover, New York City's tuberculosis program imposed extreme hardships even as it promised liberation from a terrible scourge. As a result, health officials often met resistance.

Health Department Regulations and Services

The New York City Department of Health battled tuberculosis in various ways. An 1894 regulation declared the disease to be infectious and communicable and required public institutions to report the names and addresses of everyone diagnosed with it. Two years later, the Department of Health prohibited spitting on the floors of public buildings, railroad cars, and ferryboats. An 1897 regulation required private physicians to report cases of tuberculosis to the department. In 1901 the department instituted a policy of forcibly detaining tubercular patients who refused to obey regulations.[5]

The Department of Health also conducted one of the first major health education campaigns, dispatching medical inspectors and nurses to advise patients at home and distributing a circular entitled "Information for Consumptives and Their Families."[6] In addition, the department provided various free services, such as disinfecting lodgings after the death or departure of tubercular persons and examining sputum to diagnose tuberculosis.

In 1903, the department converted a vacant pavilion at Riverside Hospital, the isolation hospital on North Brother Island, for the use of tuberculosis patients. The following year, it opened the Clinic for the Treatment of Communicable Pulmonary Diseases in Manhattan, the first facility of its type to be established by a US city; similar clinics were subsequently opened in Brooklyn and the Bronx. And in 1906, New York became the first city to operate its own sanatorium, establishing a facility at Otisville in the Catskill Mountains.[7] In the early 1900s, as today, tight budgets prevented health officers from fulfilling many of their goals.[8] Nevertheless, New York boasted an extensive array of services, offering cura-

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FIGURE 1–Tubercular children drinking milk and eating eggs at Bellevue Hospital. Courtesy of the Bellevue Hospital Center Archives Chest Collection.

tive medicine as well as prevention at a time when many cities had only fledgling health departments.

Targeting the Poor: The Growth of Charity Organization Societies

Affluent New Yorkers were not the primary objects of the Department of Health's services and regulations. The determinants for forcible detention of tuberculosis patients included "the financial resources of the family," thus ensuring that rich and poor were treated very differently.[9] A compromise with the medical profession enabled individuals who could afford private physicians to avoid supervision by department personnel. Most affluent New Yorkers also were exempt from mandatory disinfection of homes and belongings.[10] Those requiring institutionalization entered private hospitals and sanatoria, not city facilities. To understand the impact of public health interventions, then, we must focus on the poor.

Modeled on a British organization founded in 1869, charity organization societies spread rapidly through American cities during the late 19th century. The New York COS, which opened in 1882 and collaborated closely with the Department of Health in many phases of its tuberculosis work, soon became the most important charitable agency in the city. Like other such societies in both the United States and Britain, it initially attributed poverty to the moral failings of the poor, ignoring the social and economic forces that shape individual behavior.[11] After the turn of the century, COS staff increasingly came to acknowledge that poverty did not stem solely from individual deficiencies, but the organization never wavered in its determination to distinguish between deserving and undeserving applicants. An important criterion in the distinction was compliance with medical advice.[12] District offices conducted the business of each COS. A paid agent visited the home of every relief applicant, conducted a thorough investigation, and then reported to the district committee, which decided whether to grant assistance and, if so, in what form.

The COS assisted the Department of Health by organizing the Committee for the Prevention of Tuberculosis; committee members included both COS leaders and prominent health department physicians. During its first 2 decades, the committee published a handbook on tuberculosis prevention, investigated overcrowding at Metropolitan Hospital, established both open-air classes for children with tuberculosis and a day camp for adults, organized an association to coordinate the activities of public and private tuberculosis clinics, and convinced the city government to increase its allocation for tuberculosis control.[13] The COS also promoted client adherence to the Department of Health tuberculosis regime. Charity workers monitored patients' behavior at home, informed them about the closest clinics, escorted those unable to travel alone, helped clients fill out applications for hospitals and sanatoria, and tried to ameliorate the problems that institutionalization created for both patients and family members.

Although the COS stressed the virtues of persuasion, it often resorted to compulsion. The most common coercive measure was withdrawal of relief. In situations of extreme need, the COS provided emergency supplies of groceries and fuel as soon as families applied. The organization discontinued such help whenever families demonstrated unworthiness—for instance, by rejecting medical advice. Some charity workers made the offer of assistance contingent on compliance. In a few cases involving children, the COS solicited the intervention of the Society for the Prevention of Cruelty to Children. In addition, the COS staff informed the Department of Health about people who failed to exercise proper precautions and requested that the department forcibly detain them.

The fact that the COS imposed its own system of rewards, sanctions, and surveillance, of course, limits the generalizability of this study. Nevertheless, turn-of-the-century health departments commonly relied heavily on voluntary groups to spread their message and enforce their measures[14]; COS clients, therefore, were not unusual in experiencing a public health campaign through the mediation of charity workers.

Clients of the Charity Organization Society

Surveys conducted by the New York COS help to introduce the clients. A 1910 study reported that 12% of the 5387 families on the COS roster had at least one member with tuberculosis.[15] Immigrant groups—excluding Jews, who were referred automatically to the United Hebrew Charities—dominated the caseloads. Almost all employed men were unskilled manual workers, most of whom earned between $12 and $14 a week. Most families lived in three-room apartments, paying between $8 and $12 a month.[16]

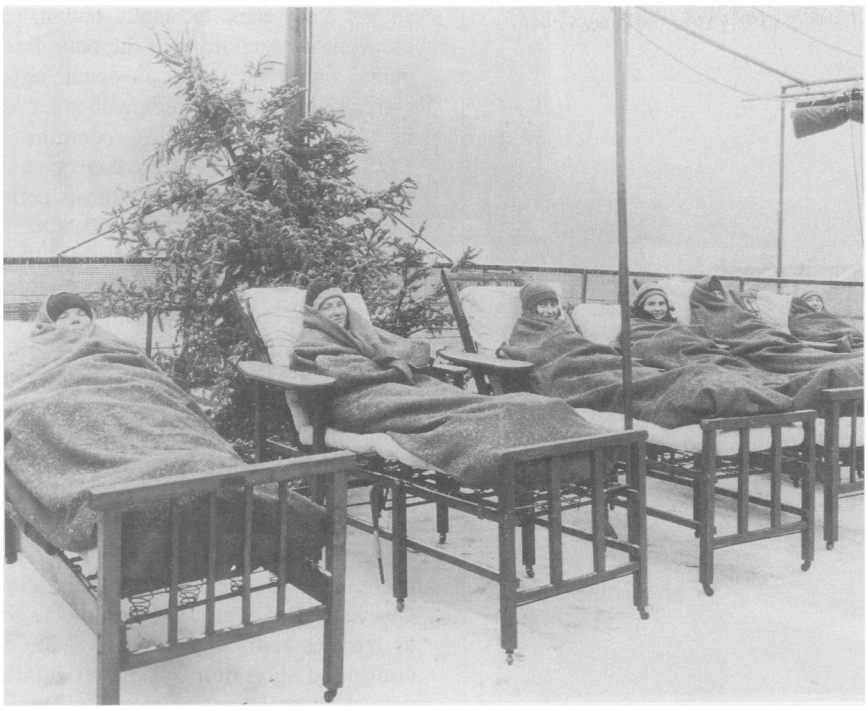

FIGURE 2–Tubercular patients resting at a day camp on a Bellevue Hospital ferryboat docked in the harbor. Courtesy of the Bellevue Hospital Center Archives Chest Collection.

The case files of the organization included a standard intake form containing such basic information as the names, addresses, and ages of all family members, and the occupations of those in the labor force. On subsequent pages, COS staff recorded the results of interviews with neighbors, relatives, friends, employers, and clergy. Charity workers also provided notes on every interaction with family members, whether at home or at the COS office. These entries both summarized conversations and recorded the investigators' impressions of the household. In addition, several files contain correspondence, medical records, and reports from various institutions, including hospitals and sanatoria.

This essay draws on the 119 COS case files between 1894 and 1918 located at Columbia University in which at least one family member had tuberculosis. Because some of these families had only brief interactions with the COS, the data cannot be quantified. Approximately one third, however, remained in the caseload for years, and their voluminous records are especially valuable.

Unfortunately, the records provide limited information about the clients' health beliefs. In interacting with COS staff, clients had to frame their appeals in language calculated to appeal to the organization, hiding aspects of themselves that did not conform to its notions of deservingness. Because charity workers exhibited enormous faith in the germ theory, clients may have been reluctant to assert that they subscribed to an alternative explanation of disease causation.

The COS typically attributed client noncompliance to ignorance but often failed to specify what it thought clients did not know. In many cases, what charity workers interpreted as poor people's lack of knowledge of germs may have been refusal to adopt middle-class modes of behavior. Various components of the tuberculosis program advanced the goal of assimilation. Instructions about sleeping arrangements, for example, addressed moral concerns as well as medical ones. By advising tuberculosis patients to sleep alone, nurses and charity workers could seek to control not just contagion but also promiscuity, which privileged members of society associated with overcrowding.[17] Because the discovery of the tubercle bacillus made disposal of sputum an urgent issue, it is not surprising that educational circulars provided detailed instructions about hygiene. Warnings about expectoration served to control a practice the wealthy considered abhorrent as well as a source of infection. The concern for cleanliness, however, shaded easily into a concern for neatness and order. Both Department of Health nurses and COS staff supervising tuberculous people noted whether beds were made, children's faces washed, and rooms kept tidy.

If the records do not enable us to gauge the extent to which the health beliefs of clients coincided with those of charity workers and health officials, they do provide insight into the everyday context within which the clients experienced public health measures. Recent studies demonstrate that life circumstances are the most important factor in explaining compliance with medical regimes.[18]

Fears of Stigma

Some effects of the tuberculosis program were indirect. As information about the communicable nature of the disease spread, stigma increasingly attached to its victims.[19] Even family members sometimes shunned tuberculosis sufferers. In one particularly dramatic case, a man dying of tuberculosis shot his estranged wife and attempted suicide. According to a newspaper account, the man had asked his wife to live with him again, but she had refused, citing Department of Health advice. He wrote in a note, "I am tired of life. . . . My wife threw me down. . . . Since that time I have been in the hospital three times. She would not come near me. . . . It seems a crime to be ill."[20] In another case, worries about contamination prevented the wife of a sanatorium patient from "doubling up" with her relatives, a popular method of saving money among the poor.[21]

The isolation surrounding tuberculosis victims should not be exaggerated. In the two cases cited above, relationships may well have deteriorated prior to the diagnosis. The overwhelming majority of families insisted on caring for patients long after the COS and Department of Health implored them to stop. Many family members also continued to share beds, dishes, and towels with the sick—to the horror of charity workers and health officials.

It was outside their circle of intimates that COS clients were more likely to be treated solely in terms of their disease. Some lost work when employers learned about their conditions. Homeworkers were especially vulnerable. Upper-class people refrained from sending washing or sewing to women when any family members suffered from tuberculosis. The presence of tubercular relatives also prevented women from caring for orphans during the day or advertising for boarders.

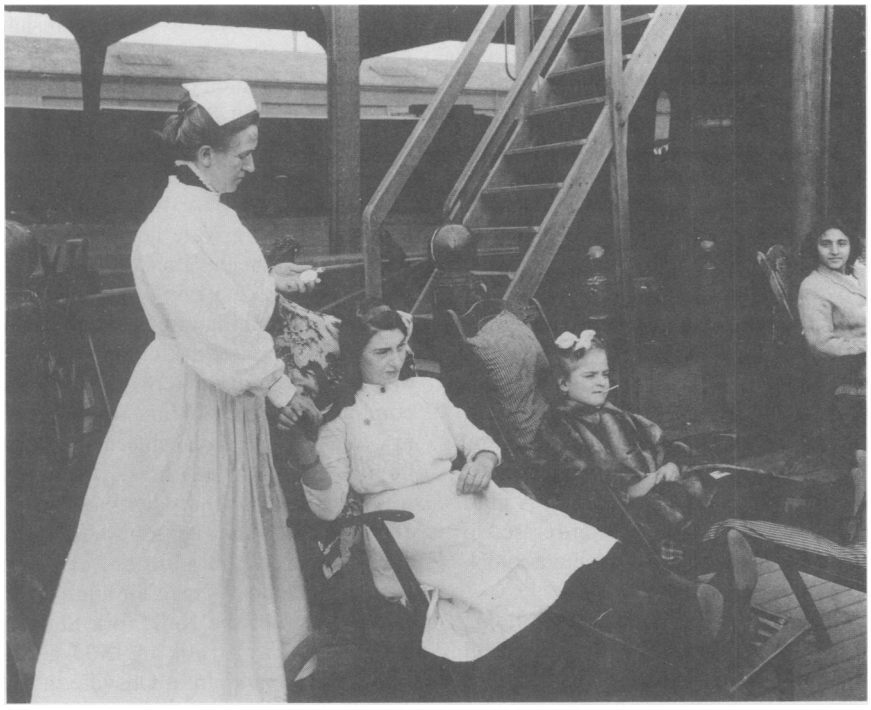

FIGURE 3–A nurse taking the temperature of girls on the Bellevue Hospital ferryboat. Courtesy of the Bellevue Hospital Center Archives Chest Collection.

Diagnosis

The case files provide more extensive information about the direct impact of public health measures. Because the COS made adherence to prescribed medical regimens a condition of receiving assistance, charity workers carefully reported client responses to all recommendations. Many charity workers described themselves as engaging in long and arduous campaigns to secure compliance with Department of Health advice.

Diagnosis was the first hurdle for health workers to overcome. Many people, of course, had been labeled tubercular before they entered the COS roster; some had been referred by clinic doctors and nurses. But COS staff watched all clients for tuberculosis symptoms and urged those who showed suspicious signs to report to clinics for medical assessments. Most initially refused, insisting that they suffered only from trivial complaints.

Charity workers may have been predisposed to discover the disease among their clients. Reflecting cultural anxieties about contamination, middle-class observers associated tuberculosis with the bodies of poor people, especially immigrants.[22] For their part, the clients may have been overeager to dismiss symptoms. It also is possible that some people who acknowledged that their symptoms might indicate tuberculosis evaded diagnosis because they feared the social consequences.

Diagnostic methods remained inexact throughout the period we are examining, producing a high rate of false positives.[23] Nevertheless, most clients refrained from expressing to the COS any doubts they may have had about the designation that doctors conferred upon them.

Issues behind Noncompliance

Regardless of the severity of their illnesses, all patients were expected to obey Department of Health advice. Because COS clients had a strong interest in convincing charity workers that they were in compliance, the COS assumed that it could not take client accounts at face value. Thus, staff arrived at homes unexpectedly to inspect beds, food, windows, and sputum cups. Such examinations uncovered numerous tubercular people living in cramped, dark, and unsanitary quarters, occupying the same beds as others, deviating from the prescribed diet, and allowing sputum cups to overflow.

Both charity workers and health officials were well aware that material conditions often prevented compliance. Nourishing food and new beds were expensive, and many apartments were too small to accommodate more beds. Many tenement rooms were windowless; the windows that existed often opened onto air shafts rather than the street, thus providing neither the sunlight nor the ventilation that health officials considered essential. The dilapidated condition of buildings, the soot and ashes produced by coal-burning stoves and kerosene and gas lamps, and the serious overcrowding all made dirt unavoidable.[24]

To ameliorate some of these problems, both charity workers and health officials participated actively in the campaign for tenement house reform.[25] In addition, many clinics distributed eggs and milk to needy patients.[26] The relief committee of the COS's Committee for the Prevention of Tuberculosis (CPT) raised funds to furnish new beds, special diets, sputum cups, and occasionally even help with moves to sunnier and airier apartments; when clients lacked space for extra beds, the Committee provided folding cots to be used in the kitchen at night.[27]

However, competing needs sometimes interfered with clients' use of this assistance. A pregnant woman who received a new bed from the CPT saved it for her forthcoming confinement rather than giving it to her tubercular son to enable him to sleep alone.[28] Some assistance was inadequate. The supply of eggs, for example, occasionally fell short of the number that doctors prescribed; a few people received moving expenses but not help in paying higher weekly rent. Moreover, some clients resented being pressured to leave their apartments. Moving disrupted the patterns of social exchange on which poor people depended. A West Indian woman rejected repeated attempts to compel her to abandon her dark rooms, stating that she preferred to remain in an integrated neighborhood rather than resettle in the "colored" one where a charity worker believed she belonged.[29] Because janitors typically lived in damp and fetid basements, they were especially likely to be told to find new quarters. But such clients lost free rent as well as familiar surroundings when they moved.

Although charity workers sought to provide some of the resources clients needed to follow Department of Health advice, they were unwilling to relax their standards of hygiene, which imposed unbearable burdens on poor women. Many of these women lacked indoor plumbing and thus had to lug pails of water up several flights. Some could eke out time for household chores only after long days in factories,

laundries, or upper-class homes. Homework also consumed time while increasing dirt and congestion. Onerous child care and nursing responsibilities further diminished the ability of these women to meet charity workers' expectations. Dying patients created special problems. COS staff enjoined caregivers to observe "absolute cleanliness,"[30] but most poor women were virtually incapable of following such advice. People in the final stages of consumption coughed and vomited frequently, soiling themselves, their beds, and sometimes even the rooms around them.[31]

Other instances of noncompliance also make sense when viewed from COS clients' perspective. Despite the directive to sleep alone, very sick patients were unwilling to forgo the comfort of sharing beds with others. A woman who kept her windows shut at night in violation of a nurse's decree explained that she did not want to "freeze to death."[32] Recommended foods, especially raw eggs, revolted many people.

Outpatient Services

In addition to altering behavior, infected people were expected to accept various health services. As noted, the Department of Health sent nurses and inspectors to homes to dispense advice and monitor compliance. In some cases, however, language barriers impeded interactions. In addition, some clients objected to the intrusive nature of the visits.

Clinics elicited far more complaints than home visits. Clinic care was available to the tubercular poor not only in the facilities established by the Department of Health but also in a variety of hospital dispensaries. The Association of Tuberculosis Clinics, formed under the auspices of the Committee for the Prevention of Tuberculosis in 1906, coordinated the activities of the various clinics and assigned each a specific service area.[33] Although the clinics offered little treatment, they required patients to return regularly, sometimes as often as once a week. Because charity workers contacted clinic staff to check that appointments had been kept, clients had to justify all absences.

Although the number of clinics grew during the early 20th century, many clients still lived far away and thus had to pay the cost of carfare. Some were too weak to make the trip, and some women could not leave work or household duties to accompany young children. Those who did reach clinics had to wait hours to be called; some left without seeing doctors. Moreover, many clinics were open very few hours, and mostly during the workweek.[34] As a result, many clients forfeited wages when they went, and some lost jobs. A 14-year-old boy who supported his mother and seven younger siblings twice attended a Department of Health clinic after work on Friday. Because he arrived too late to be examined, a charity worker insisted that he allow a half day for his next visit. When he left work at noon the following Friday, his employer fired him.[35]

Not all barriers to compliance were material in nature. Because few interpreters were available, many immigrants had difficulty communicating with doctors and staff. Further, the interactions robbed some patients of dignity. Two women reported that doctors were "rude" to them.[36] A third woman complained that a doctor refused to examine her daughter until the mother took the girl home and cleaned her.[37]

The COS encouraged many clients awaiting admission to sanatoria to attend day camps as well as clinics. The Committee for the Prevention of Tuberculosis established the first tuberculosis day camp on an experimental basis in 1906 in a discarded ferryboat docked in the Hudson River. Arriving at 9 AM, patients were expected to spend the hours until 5 PM sitting outside, consuming the special food distributed, and abiding by the regulations intended to prepare them for sanatorium life. Although lack of funds compelled the committee to abandon the project after a year, three hospitals opened similar camps in conjunction with their tuberculosis clinics. In 1910, the Department of Health assumed some responsibility for the governance of the camps.[38]

Many COS clients enrolled reluctantly. Some objected to the transportation required. The mother of two school-age children attending a day camp in 1910 told a charity worker that she "fears they will be run over in traveling back and forth."[39] The case file of an Italian immigrant man noted that he "prefers staying in the park which is near their home, rather than walk[ing] down to the day boat."[40] He also may have wanted to escape the surveillance exercised by day camp staff. A 21-year-old man participating in a camp in 1914 registered his protests by disobeying the rules. Because he smoked and fought with other patients, he was eventually discharged.[41]

Inpatient Care

The greatest resistance was to institutional placement. The major facilities for the tubercular poor were Metropolitan Hospital, operated by the Department of Public Charities on the site of the old almshouse on Blackwell's Island, and the special tuberculosis pavilion opened by the Department of Health at Riverside Hospital. Five private hospitals received subsidies from the Department of Public Charities to provide tubercular care for the poor.[42] In addition, a few private hospitals reserved free beds for tubercular patients.[43]

During the late 19th century, poor people seeking sanatoria care could try to find a free bed in a private institution or go to one of the boardinghouses that sprang up in communities surrounding sanatoria. But few free beds were available, and boardinghouses charged high fees. One woman reported in 1906 that she was taking in extra washing to pay her son's board in Liberty, New York; in addition, his friends were "getting up a benefit for him."[44] After the openings of the New York State sanatorium at Ray Brook in 1903 and the municipal sanatorium at Otisville in 1906, those facilities became major resources for COS clients. But both required applicants to wait several months for admission, and Otisville excluded noncitizens, a serious problem for many COS clients.

Because access to both hospitals and sanatoria remained limited throughout the period we are examining, some COS clients appealed for help in finding beds. Many more clients, however, faced the opposite problem—staving off pressure to enter institutions. Charity workers often attributed client resistance to irrationality. Because poor people were "superstitious," "fearful," and "prejudiced," they believed even outrageous rumors about institutions and refused to listen to the arguments charity workers and doctors advanced. Nevertheless, the COS also acknowledged that many facilities available to the poor offered substandard care. In 1911, the COS Committee on the Prevention of Tuberculosis issued a report castigating the city for the "disgraceful" overcrowding in Metropolitan Hospital. Beds "regularly lined" the halls; many patients were forced to sleep on mattresses on the floor.[45]

A client who left Metropolitan Hospital "because he could not stand the place" vividly described conditions in a letter to the COS in 1913. The bedding he received had been used by other patients without having been washed or even aired. His blankets "actually stank so bad that I could not pull them up near my neck." Hundreds of men shared the same two towels and single cup in the lavatories.[46]

Hermann M. Biggs, the chief medical officer of the Department of Health,

acknowledged that many "advanced cases" refused hospital care, but he asserted that "they joyfully accept an opportunity to go to a sanatorium in the country."[47] Yet sanatoria inmates also had various concerns. Many found the cold intolerable during the periods they were compelled to stay outside. The work requirements also infuriated patients. Biggs argued that work assignments prevented inmates from lapsing into the idleness believed to be congenital in the poor.[48] Many COS clients, however, could not see the point of working for free. Some also criticized their specific assignments. A girl who left Otisville after 6 weeks in 1911 reported, according to the case file, that "patients' health was not considered at all in the work required." As her mother explained, the girl washed dishes "in a room so full of steam that she could hardly breathe."[49]

Both hospitals and sanatoria imposed harsh–even punitive–regimes intended to inculcate discipline and self-restraint.[50] But in institutions as at day camps, many COS clients refused to abide by the rules. They smoked, swore, "scuffled" with others, hid liquor under their beds, were "impertinent" to doctors, and left the grounds without permission. In some cases, infractions led to dismissal.

Hospital and sanatoria placement also threatened the economic and social survival of the entire family. As the Committee for the Prevention of Tuberculosis wrote in 1906:

> Even the scanty and occasional earnings of a consumptive are important to many a poor family, and frequent objection to hospital care is raised by father, mother, husband, or wife, even though the bread-winner power of the one needing such care has been reduced to the lowest point, if not, indeed, entirely taken away by sickness.[51]

Health officials and charity workers frequently insisted that institutionalization would increase productivity, but families needed an immediate return. One man refused admission to Otisville in 1914 in order not to leave his family "penniless."[52] The departure of older children represented an economic catastrophe to other families. One boy had just reached 14, the legal working age, when he was diagnosed with tuberculosis and urged to enter a sanatorium. Although the father was employed, his income was insufficient to provide for the family, which included seven younger children. The mother protested that she would be unable to continue to pay the rent without her son's wages.[53]

The departure of women deprived many households of their primary caregivers. Although COS staff sought to place children with relatives or in institutions, that was not an acceptable remedy to the clients. One woman protested that the commitment of her children would mean that they were permanently lost to her—a reasonable fear at a time when infectious diseases periodically struck asylums, killing a very high proportion of the children.[54]

Although institutionalization sometimes relieved family members of the burden of nursing care, it also imposed new anxieties and responsibilities. One pregnant woman stated that she "could not endure the thought of sending her husband to the hospital" because "the worry and strain" would be too great during her approaching confinement.[55] The problem of obtaining news of institutionalized patients intensified worries. When family members spoke little or no English or lacked telephones, communication with institutional staff was extremely difficult. And many clients suspected that institutions failed to provide accurate information or to notify them promptly in emergencies.

Visiting institutionalized patients also was onerous. Hospitals for poor people typically restricted visits to 2 or 3 hours a week[56]; child care and work responsibilities often prevented women from taking advantage of those times. Few families could afford the train fare to Otisville, located 75 miles from New York City; in addition, travelers had to pay accommodation for at least one night.

Institutionalization occasionally involved still other obligations. A charity worker explained why a man left a private hospital after 3 days in 1904. His wife stated

> [that] when she went to see him on Sunday, she was told she would be compelled to do his laundry work and provide all necessary toilet articles, and would also have to get him a new suit of clothes, as the patients who were able to be about, must be neatly dressed. As it would be impossible for her to do all this, she brought the man home with her.[57]

Disinfection

The Department of Health disinfected rooms after the death or departure of people with tuberculosis. The department also removed carpets, clothing, pillows, mattresses, and bedding; most were not returned. As Biggs wrote, "Tens of thousands of mattresses, comfortables, pillows, etc., from lodging houses and tenement houses which have been exposed to infection...have been destroyed under this ruling."[58] Although Biggs asserted that the department destroyed only possessions "without value,"[59] few COS clients could afford to replace the belongings they lost. One charity worker found several family members sleeping on three old comforters on the floor after the Department of Health burned their mattresses, sheets, and pillowcases.[60]

Landlords also had responsibilities. Department of Health inspectors who found premises too dirty to be adequately disinfected ordered landlords to undertake renovations. Biggs acknowledged that this requirement often deterred landlords from renting to tubercular people.[61] In addition, some COS clients received eviction notices after family members entered institutions because landlords were angry about the department's demand that they repaint and repaper walls.

Protecting Children

Some facilities sought to prevent tuberculosis rather than cure it. In 1909, Alfred Hess, a New York City pediatrician, established a "preventorium" for poorly nourished children who had been exposed to infection at home.[62] The facility accommodated 150 children between ages 4 and 14, who stayed an average of 3 months.[63] "The plan of treatment is simple," Hess wrote. "Plenty of good food, a twenty-four-hour day in the open air, an intimate acquaintanship [*sic*] with the fields and woods, and a practical lesson in cleanliness and hygiene."[64] The Hospital Admission Bureau of the Department of Health assumed responsibility for selecting the children for attendance.[65] Health department doctors also often recommended that children at high risk of tuberculosis be sent to boarding homes in the country for a few weeks; the COS made the arrangements for children in client families and raised money to pay for the trips.

Although Hess argued that parents willingly relinquished even very young children,[66] the COS case files suggest otherwise. In two cases, requests for preventorium care came when families were especially vulnerable. One charity worker explained why a woman whose husband had just died of tuberculosis rejected a doctor's recommendation that she send the children to a preventorium: "She said she feels sick and melancholy and that if the children were to go she is sure she would feel worse. Under no circumstances will she part from them."[67] Another mother refused to surrender her daughter after losing two younger children

to diphtheria.[68] Although the length of stay in boarding homes was much shorter than that in the preventorium, the prospect of sending children to the country also provoked fierce resistance.

The difficulty of visiting children may have intensified parental opposition. As Hess wrote, he wanted his facility to be "far enough from the city for the items of expenditure of time and money to act as a deterrent to frequent visits on the part of mothers."[69] Parents who could afford trips to the country sometimes were denied permission to see their children.

Parents also may have been reluctant to subject children to the scrutiny of people who considered themselves socially superior. One boarding home owner complained that two boys sent by the COS had "no nightclothes nor proper underwear," were "inclined to be somewhat wild," and were "not very cleanly in person." Although the owner subsequently reported that the boys were "improving in manners," the parents may have been less pleased with the change.[70] Another boarding home owner expelled a boy after finding vermin in his hair; the boy was accused of infecting the owner's wife and child.[71] Because moral uplift was central to Hess, preventorium staff also may have harshly judged the children in their charge.

Parents had their own fears and suspicions. Pressed to send her daughter to the country, one woman demanded assurances that the boarding home "is a good respectable place and that those who control it have a good reputation."[72] Just as a boarding home owner refused to tolerate a boy with verminous hair, so too was a mother described as being "very worried" by the discovery of nits in her daughter's hair after the daughter returned from the country.[73] One man who was able to visit his son and daughter in a country house was "not pleased with the appearance of the place." The food was "poor" and did not include milk and eggs. His wife found bedbugs on the children's clothes after they returned. In addition, the girl had stomach cramps, which the mother attributed to the crab apples the child had been permitted to eat.[74] Children also protested. Many begged to be taken home from the boarding homes. Two older boys ran away from the preventorium.[75]

Discussion

Some historians argue that Biggs was attentive to the needs of the poor. Comparing him with a contemporary Milwaukee health officer who incited immigrant communities to riot, Elizabeth Fee and Evelynn M. Hammonds note that Biggs took pains not to antagonize the poor through excessive severity.[76] Daniel M. Fox asserts that the Department of Health hospitalized patients only after "careful consideration of the economic and emotional effects on their families."[77] But if poor people did not protest collectively, many resisted individually. They delayed seeking diagnosis, disobeyed the advice promulgated by the Department of Health, attended clinics irregularly, and either refused to enroll in hospitals, sanatoria, and preventoria or fled soon after arrival.

It is important not to exaggerate the extent of this resistance. Long waiting lists for institutional beds and overcrowding at clinics remind us that the New York City tuberculosis program garnered substantial support. Some evidence, however, indicates that COS clients were hardly alone in objecting to various measures. Although the recommended length of stay at Otisville was 3 months, 44% of the patients left before that time.[78] According to a 1912 Department of Health report, many patients visiting clinics gave false names in order to avoid being visited by department nurses and inspectors.[79]

We also should be cautious about romanticizing resistance to public health authority. Social theorists currently emphasize resistance in order to describe patterns of domination without casting subordinate groups solely as victims. But our desire to restore agency to poor New Yorkers should not blind us to the fact that the advice they disregarded often addressed real needs. Many tuberculosis patients who refused to sleep alone, clean sputum cups adequately, or stay in hospitals or sanatoria endangered uninfected family members. Although we no longer place faith in the therapeutic value of rich food for tuberculosis sufferers, contemporaries had reason to believe that any deviation from the prescribed diet brought serious risks.

Nevertheless, client responses to the tuberculosis program often made sense when viewed from their perspective. Clinic visits meant the loss of wages and sometimes jobs. Institutionalization devastated families financially and emotionally. Standards of hygiene imposed unbearable burdens on women who held paid jobs, had onerous child care and nursing responsibilities, and lived in tenement rooms that were overcrowded and lacked running water.

The substantial resistance documented in the COS case files may well have undermined the efficacy of New York City's program of tuberculosis control. The essay suggests that policymakers should evaluate public health campaigns very broadly, asking not just about their ability to reduce disease mortality but also about their overall impact on the lives of targeted populations. Today, as during the late 19th and early 20th centuries, such campaigns often impose hardships on poor people, even while improving their health. □

Endnotes

1. See, for example, Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton, N.J.: University of Princeton Press, 1982), 76–121; Guenter B. Risse, "Epidemics and History: Ecological Perspectives and Social Responses," in *AIDS: The Burdens of History*, ed. Elizabeth Fee and Daniel M. Fox (Berkeley, Calif.: University of California Press, 1988), 33–66.
2. These files are located in the Community Service Society (CSS) Archive, Rare Book and Manuscript Library, Columbia University, New York, N.Y.
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