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CULTURE AND DISEASE  
IN NINETEENTH CENTURY SAN FRANCISCO

by

LINNEA BACK KLEE

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

MEDICAL ANTHROPOLOGY

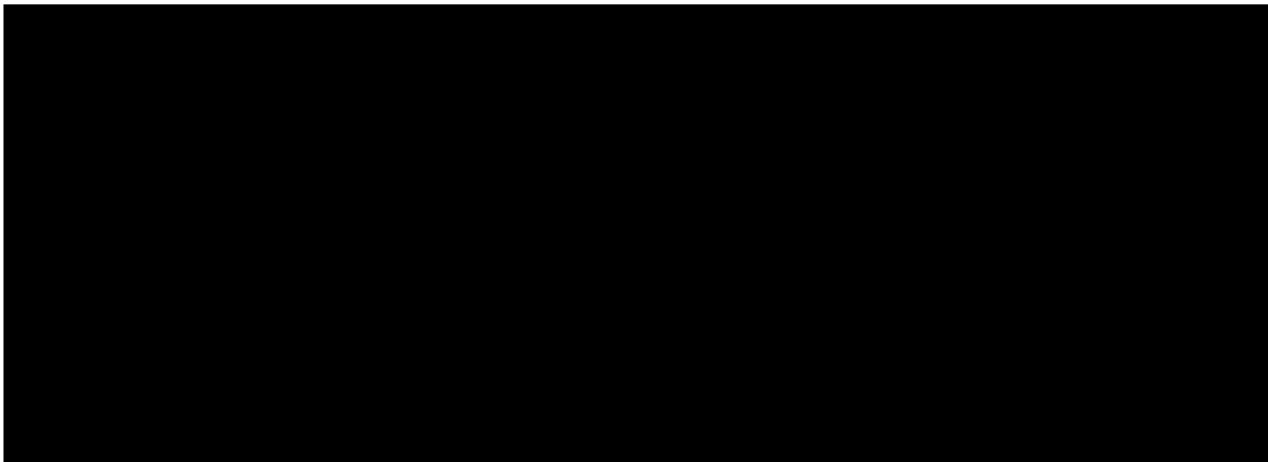
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CULTURE AND DISEASE  
IN NINETEENTH-CENTURY SAN FRANCISCO:  
PERCEPTIONS AND EXPERIENCE OF INFECTIOUS DISEASE

A disease is no absolute physical entity  
but a complex intellectual construct,  
an amalgam of biological state and social  
definition.

--Charles Rosenberg 1962: 5



ABSTRACT: CULTURE AND DISEASE IN NINETEENTH-CENTURY SAN FRANCISCO:  
PERCEPTIONS AND EXPERIENCE OF INFECTIOUS DISEASE

By the 1870s a range of infectious diseases dramatically demonstrated changes produced by industrialization and urbanization in San Francisco. San Francisco physicians struggled to control not only diseases themselves, but also the exclusive right to interpret, define and treat them. But disease victims turned to a number of popular medical alternatives. A proliferation of health ideologies and therapeutic choices accompanied the city's early development.

This historical and medical ethnography of 1870s San Francisco examines the cultural construction of infectious disease. It applies the theoretical perspective of medical anthropology to medical history. It examines competing medical ideologies of this period, and presents people's own disease experiences from letter and diary manuscript sources. It examines specifically the socioeconomic setting of a newly urbanized city and the impact of enormous population growth. Physicians argued that San Francisco would be the healthiest of cities were it not for a poor sewage system and the influx of tubercular patients attracted by the city's climate. Examination of disease statistics reveals that foreign-born immigrants and their children were the usual victims of infectious disease. Both "regular" and alternative medical ideologies were based on an equilibrium model of health which did not recognize disease contagion. Manuscript sources illustrate the actual use of all medical alternatives to treat infectious diseases, and belief in their contagion.

Medical professionals a century ago acquired cultural authority and hegemony over alternative practices. In spite of San Francisco physicians' rejection of incipient germ theory, they identified their interpretations of

disease with "science". They capitalized upon a growing social endorsement of scientific approaches. Today new cultural constructions of disease continue to challenge biomedicine's authority. An analogy exists between the environmentally-caused infectious diseases of the 19th-century and chronic diseases of today. In neither case was scientific medicine able to have significant impact on disease incidence in spite of its control over social definition and action. Such examination of the cultural context of historical disease experience makes it possible for us to become more self-conscious about current interpretations of health and disease.

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## INTRODUCTION

### Then and Now

In the public mind California is fixed as a haven of medical pluralism. This circumstance is paradoxical because during the past century scientific medicine or "biomedicine" has acquired nearly absolute hegemony over American health care. But many alternatives today challenge the dominant model, such as midwifery, homeopathy, megavitamin therapy, herbals, wholistic health exercise and diet regimens, and spiritual and psychological therapies such as yoga, bodywork, meditation, "rolfing" and many others. An increasing number of health seekers are dissatisfied with biomedicine's ability to explain and treat the socially defined illnesses from which people currently suffer and seek relief.

In this dissertation I show that a wide pluralism in therapeutic choices also existed a century ago. The precursor to present biomedicine was only one option among many. I analyze the diverse historical context from which biomedicine's eventual predominance evolved. Today the San Francisco Bay Area is a major location of modern medical alternatives. A century ago a proliferation of health ideologies not unlike those available today accompanied and capitalized upon the early development of the city. A new and western city, San Francisco experienced late in the 19th-century the problems and conflicts characterizing industrialization and urbanization. Chief among these was the occurrence of infectious disease.

The severe endemic and epidemic diseases of this period were primarily urban phenomena. They accompanied social change and a redefinition of the nature of cities. The advent and prevalence of disease were associ-

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ated with foreign-born immigrants. Urbanization, industrialization and migration brought polluted water, poor and contaminated food and milk, overcrowded housing, poverty, and sanitary ignorance. These conditions were disclosed by sanitary inspectors and public health reformers. Socio-cultural factors were also largely responsible for the eventual eclipse of infectious diseases. But thorough study of the sociocultural context of the 19th-century "sanitary revolution" remains to be done.

The revolution in public health that was to prevent infectious diseases in the future was well under way in European cities by the 1870s. This movement was also to contribute to the near elimination of such diseases from American cities. As cities grew, so did recognition that a general improvement of the standard of living was necessary. Public health efforts brought miraculous changes in the length and quality of life for average people.

The growth of scientific medicine was very much a part of the urban context in which rapidly spreading infectious diseases demanded most of the attention of professional and alternative medical practice. The decade of the 1870s just preceded the discoveries in bacteriology that were to revolutionize etiological understanding of these diseases. But at the time of which I write neither professional nor alternative medical interpretations could resolve the baffling incidence and spread of diseases such as diphtheria, measles, cholera, typhoid, scarlet fever and tuberculosis.

In the 1880s scientific bacteriology coincided with the revolution in public health in America. Consequently, biomedicine received a cultural endorsement that assured its gradual acquisition of power over medical interpretation and treatment. Only recently has this cultural authority



again been seriously challenged by advocates of alternative approaches in both preventive and therapeutic medicine.

Evidence of this state of transition from the "Golden Age" of biomedicine to a period of greater competition from other health ideologies and therapeutics may be found in a series of reports prepared recently for the California Board of Medical Quality Assurance (Public Affairs Research Group 1981). This board is the regulatory agency that oversees the definition and licensing of medical practice in the state. In addition to physicians, the state regulates allied health care occupations such as chiropractic, dentistry, nursing, optometry, osteopathy, pharmacy and psychology. But alternative therapies such as those mentioned on the previous page have not been recognized as part of legitimate medical practice in the state. Recent concern over the definition and licensing of medical practice resulted in a series of colloquia to discuss where these alternatives fit into public regulation of medicine. Alternative medical approaches have begun to be perceived as real threats to the medical establishment and/or to the population, and are generating heated philosophic and political confrontations.

This ideological and political conflict is in no way new in the state of California. Its origins and analog may be seen a century ago in 1870s San Francisco when the biomedical approach competed with a number of health care alternatives striving for practical domination. The struggle and ultimate success of this scientific ideology in the history of American medicine has been well documented by medical historians and medical sociologists. But the products of medical historians have been branded "iatrocentric" by some because they focus on the history of great men and institutions and stress a progressive development in medical ideas.



Medical anthropology can view this history from an entirely different perspective.

What needs to be done is to explain why certain social definitions of disease came to be predominant. By introducing a social science "from the bottom up" medical anthropology can refocus some of the stultified antecedent discussions and stress the experience of the sick rather than imposed professional definitions of illness. Whenever a social group, such as today's professional medical establishment, acquires power over others by non-coercive means it has been granted a general cultural approbation by members of the larger society. The modern scientific approach to disease etiology and therapeutics received this sanction because of its ability to resolve a critical ambiguity; i.e., the explanation and cure of acute infectious diseases. Again today those who suffer from chronic and unsuccessfully diagnosed and treated illnesses seek satisfactory explanations and solutions. Approaches proposed thus far have not been dramatically successful. In consequence, a movement has developed in opposition to the harsh and traumatic accompaniments to surgery, drug therapies, high technology diagnostics and lengthy hospitalization. People are turning to gentler and more humane therapies of wholistic, preventive health approaches, whether or not they are effective in scientific terms. Clearly, some larger needs in the social definition of illness, particularly a sense of powerlessness, are being appealed to.

If the traditional historical narrative is recast in this way, a dramatic analogy between 1870s and 1970s (or 80s) San Francisco emerges. Many medical historians have cited the conquest of infectious diseases as the turning point in the evolution of the victory of biomedicine

over its competitors. These diseases were socially defined and grouped before their bacterial or viral etiologies were known. As "miasmatic" and "zymotic" diseases they joined tuberculosis (a "constitutional" disease) as the most frustrating challenge to 19th-century therapeutics of all kinds. They also devastated masses of 19th-century population, and defined the terrifying threat of mortality for individuals and their families throughout their lifetimes. Today these diseases account for only a small proportion of annual deaths in San Francisco (infectious and parasitic diseases 1% of all deaths, TB .2% of all deaths). Leading causes of death now are diseases of the heart, cancer, cerebrovascular disease, and other chronic non-infectious diseases (Center for Health Statistics 1979-80). Chronic diseases dwell still in a realm of ambiguity and anxiety with regard to etiological explanation and effective therapy.

Similarly, in 1870s San Francisco the ill sought relief from the ineffective and harsh therapeutics to which they were routinely subjected. They found numerous alternatives available which were certainly no more nor less useful in curing their ailments, but were more satisfactory in treating the ambiguity of etiological beliefs. Much of the success of any therapy lies in the healer's ability to treat social beliefs about disease that go beyond its physical manifestations. Those who were victorious in the power struggle to dictate the definition and treatment of infectious disease in the 1870s were the ones whose medical ideology won widespread cultural endorsement.

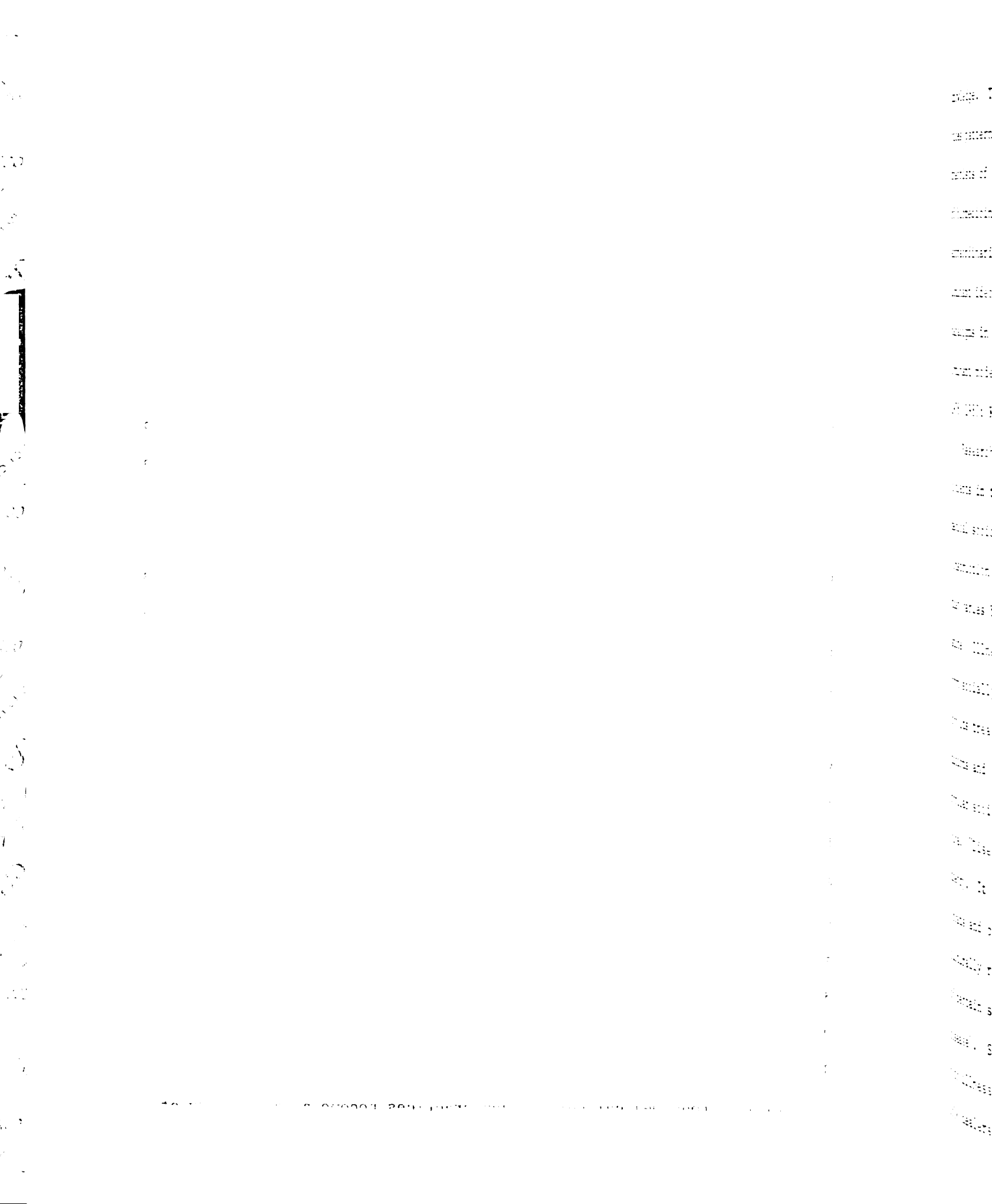
The aim of this dissertation is to examine the cultural context of infectious disease in 1870s San Francisco and the competing medical ideologies that proffered social definitions of disease and its treatment to the ill. Comparison to the current context of chronic illness in the

same place is implicit throughout and discussed in more depth in the conclusions. Since I have chosen to conduct historical research, some explanation of my orientations to medical anthropology and medical history is necessary. The rest of this Introduction makes these views explicit.

#### Cultural Construction of Illness

In the past decade or so medical anthropologists have begun to talk in terms of "ethnomedicine", referring to "those beliefs and practices relating to disease which are the products of indigenous cultural development"; or "The study of medical institutions and of the way human groups handle disease and illness in light of their cultural perspective". This point of view requires holistic consideration of the entire cultural context in which illness takes place, including its social history, a point of view often evoked, but rarely practiced. The goal of ethnomedicine is to investigate the meaningfulness of health and illness from the perspective of ordinary people (the emic perspective; see Harris 1976). The ethnomedical model attempts the phenomenological study of illness and "hermeneutic accounts of divergent interpretations of it". Beliefs, values, and world view become the focus of study. Disease is examined as a sociocultural construction, not a biological given. How it is identified and defined is regarded as culturally specific, not universal. Many medical anthropologists have studied folk illnesses that are not recognized as entities in Western medicine. They have had to develop a perspective that respects and interprets people's disease experience in sociocultural context, without relying on the Western scientific framework of disease (Hughes 1968; Fabrega 1974: 97-98, 1977; 201-210; Geertz 1975).

In any group medical beliefs and practices become a formal body of



knowledge. This medical taxonomy in the West is biomedicine. It provides patterns of action for both healers and their patients. Leading theorists of the ethnomedical perspective argue that the Western model of biomedicine is itself a culturally-specific paradigm, albeit an extraordinarily successful one. It expresses cultural values and a dominant ideology. But there are also coexisting folk or popular medical paradigms in any society, or at least divergent interpretations of the dominant model (Fabrega 1975, 1977; Eisenberg 1977; Engel 1977; Kleinman 1978, 1980; Kleinman, Eisenberg and Good 1978).

Researchers of ethnomedicine have developed some key explanatory concepts in their work. Fundamental is a distinction also made by the medical sociologist Eliot Freidson (1970) when he discusses the social construction of illness. He argues that illness is a social meaning that varies both intra- and cross-culturally, not an absolute biological state. Illness is identified and defined by lay people as a deviance from socially determined norms of health. The healing institutions chosen for its treatment are socially sanctioned by popular medical interpretations and faith in specific healing rituals. Without congruence with popular social conceptions of disease, therapeutic approaches do not survive. "Disease" is regarded as the object of biomedicine by ethnomedical theory. It refers to "abnormalities in the structure and/or function of organs and organ systems; pathological states whether or not they are culturally recognized". "Illness" is the "perceptions and experiences of certain socially disvalued states including, but not limited to, disease". Some theorists also distinguish "sickness" as a term to cover both illness and disease. It is generally understood that traditional or folk healers' orientations are toward healing of illness; while the bio-

medical approach attempts to cure disease. The reification of disease as an entity is held responsible for much of the failure of biomedicine to successfully heal. Its surrounding sociocultural context of meaning ("illness") is not taken into account (Freidson 1970; Cassell 1976; Eisenberg 1977; Fabrega 1977; Kleinman, Eisenberg and Good 1978; Kleinman 1980; Young 1982).

Another explanatory model developed by these theorists is the conceptualization of the pluralism of health care into three sectors: the professional, the popular and the folk. These structural domains have not been specifically defined by ethnomedical advocates, and they seem ominously akin to the outmoded division of belief systems into "scientific, folk, and primitive" (Klein 1979: 205). Advocates suggest that each domain has its own ideology, roles, settings, and institutions. The professional sector consists of the organized medical profession often described by medical sociologists in the West. In any society this group has the greatest legitimacy or social power. The popular domain consists of family, social network and community medical resources. It is more diffused through the society and bridges the gap between professional and folk sectors. In this domain people decide that they are sick and consult their social network as to appropriate actions. Here illness and the maintenance of health, not disease, are central. The folk sector consists of nonprofessional healers (Kleinman, Eisenberg and Good 1978; Kleinman 1980). I have adapted this model and used it heuristically to organize this thesis; but because it is so inadequately conceptualized, there are a number of problems with it, particularly when applied historically.

The contribution of ethnomedical theorists, derived from their cross-

cultural studies, is the understanding that the experience of illness is a culturally constructed form of social reality. Definitions and experiences of the same "disease" may differ cross-culturally as well as internally among the groups within a society. There are two implications of this theoretical orientation, of relevance to both anthropologists and historians.

First, it becomes clear that efforts to study experience phenomenologically or emically require an interpretive or hermeneutic methodological approach. Recognition of this necessity corresponds to criticism of empiricist sociological methods applied to historical research (to be discussed in the next section). The central problem of ethnomedical research is the interpretation of the meaning of illness experiences. Underlying cultural beliefs and values or contextual meaning is the focus (Mills 1959; Berger and Luckmann 1967; Agar 1980).

Ethnomedical studies view healing as a transactional process across the explanatory models of folk, popular, and professional domains. It is regarded as a dynamic process resulting in cultural constructions of disease. The biomedical model is rejected as having "emasculated" medical anthropology, distorting its research by dictating emphases on either healers or their patients, but not on the clinical praxis between them (Kleinman 1978, 1980; Good and Good 1980).

These theorists are attempting to follow the direction of interpretive, hermeneutic and social interaction theories. The aim of research is to reveal the social construction of everyday reality, the meanings behind observable behavior. The positivist or empirical approach of socio-cultural research is rejected as a false index of cultural reality. Rather, explanations of reality are viewed as tied to continually changing inter-

pretations of values, attitudes, rules and customs. Anthropologists, trained to study cultural differences, are aware of the need for existential doubt about one's own assumptions about reality. Clifford Geertz, following Max Weber, defines culture as the "webs of significance [man] himself has spun," and its study as a search for meaning. In the study of the culture of health, disease, and medicine, the province of medical anthropology, there is clearly a need to recognize the ideologies, norms, beliefs and motivations for action that underlie health practices. If possible attention should be given to the processual and reflexive nature of health related interactions (Garfinkel 1967; Douglas 1970; Geertz 1973: 5; Schutz 1973; Young 1976).

The second implication of ethnomedicine as well as these social theories is that the individual tends to be the focal point. The study of medical practice remains oriented towards the interaction of healer and client. Social construction of reality theorists have been criticized for the same limitation. The significance of political and economic power, social inequalities and social classes is given insufficient weight. The medical system of a society is not simply the product of negotiations between individuals and their diverse interpretations of reality. Viewed historically, these actions clearly take on significance and imperatives of their own. Traditions and institutions are formed and become the basis for unquestioned actions. Inequalities in the distribution of power preclude participation by many individuals in decision-making. Social forces also determine which people suffer from which illnesses. Medical practices become ideological, justifying historically produced social relations through which illnesses are defined and their consequences determined (McNall and Johnson 1975; Hopper 1979; Starr 1982; Young 1982).



In other terms, anthropologists have been criticized for engaging in micro-analysis rather than macro-analysis. Medical anthropologists have produced studies of specific medical systems based on fieldwork. But they have tended to ignore the role of history, change, political and other social structural forces. The "professional" ethnomedical domain receives its legitimacy because authority is given it by the society in which it exists. This process results in historical structural changes, such as occurred in the history of biomedicine in the Western world. As physicians gained cultural authority through identification with science late in the 19th-century they were able to professionalize, institutionalize and gain economic power (Janzen 1978; Starr 1981, 1982).

The success of this medical ideology rested in large part on a transition that took place after the 1880s when bacteriology made it possible to truly define diseases as entities. During the 1870s specific names were used for those diseases we call "infectious" today;<sup>1</sup> but they did not have the specific etiologies that have now given them separate existences. They were grouped not by common causation so much as by symptomatology (usually fever); and their symptoms, not their causes were treated. In past historical time even in our own society, and even when today's terminology was used, diseases were culturally defined. With our etic perspective we tend to reify diseases as entities when in reality they are situationally defined. The analyst may choose to use the biomedical model to structure his or her research as I have done in using the concept of "infectious" diseases. But he or she must not forget that this viewpoint is ethnocentric (Freidson 1970; Fabrega 1974, 1977; Rosenberg 1977: 488).

This reification of diseases as things has caused a nearly irreparable

split of "diseases" from "illnesses" in ethnomedical terms. Cross-cultural ethnomedical studies reveal that the experience of illness in any society includes associated beliefs, values, attitudes and behaviors. This understanding must be applied to the history of medical ideologies in our own society as well. An illness is "a social relation, and therapy has to address that synthesis of moral, social, and physical presentation" (Taussig 1980: 4).

Michael Taussig (1980) has argued that this extraction of disease from the context of illness is equivalent to separation of fact from value, an action that cannot occur in the examination of unfamiliar folk medical systems without great effort on the part of the researcher. But we are subjects of a dominant cultural and medical ideology in our own society and easily fall under its spell. In reality the role of healing in biomedicine is a process of redefinition of metaphysical questions raised when one becomes ill. The patient is ritually reintroduced to a cultural ideology of illness under the guise of the factual model of science. Reification of diseases ignores the different meanings given illnesses and their potential treatments individually, cross-culturally and historically. For example, as Taussig notes, the idea of object intrusion as causation of disease is culturally universal. But only in biomedicine have its associated social connotations been disengaged from this explanation. In the 1870s moral and social etiological theories were still clearly expressed. As time went on they were moved to the province of public health approaches to infectious disease. The medical profession retained only the single etiological explanation of bacteriology or object intrusion, stripped of its larger cultural reverberations.

Biomedicine need not consider issues of morality, social class,

power, inequalities in distribution of health care, or any of the other structural features of modern medicine. In considering a time in our society before this model became dominant, we need to examine not only popular and folk emic and phenomenological understandings, but the socio-political context of industrialization, migration, and urbanization. This context made possible the ideological consolidation of the biomedical viewpoint. Although I do not intend a sociological history of Western scientific medicine in this work, it is important to recognize that socio-cultural changes of the 19th-century produced an increased dependence on the skills of others in areas of life where people had previously been self-reliant. The realities of urban life and industrial labor forced people to turn to experts in matters of health, education, food production, and other fundamental social needs. The "scientific" approach in all these areas gained credence and cultural authority, and professionalized and institutionalized medicine gained social legitimacy over the alternatives discussed in this work (Hopper 1979; Taussig 1980; Starr 1981, 1982; Young 1982).

#### A Question of Disciplines

An anthropologist who chooses to carry out historical research operates under the assumption that cultural differences may be examined in time as well as space. Anthropologists cling to the concept of culture in spite of differences in its definition. Clifford Geertz defines it as "an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life". It is important to add, as he does, that sophisticated analysis using this concept must recognize its dynamic

nature: "the dialectic between the crystallization of such directive 'patterns of meaning' and the concrete course of social life" (Geertz 1973: 89, 250).

In conducting historical research the dynamic character of culture is the direct focus, but its historically transmitted nature becomes an attendant area of interest because of the implicit comparison to modern ideologies or world views in the same society. Our own "ancestors" did indeed conceptualize the world very differently; and these distinct world views both produced and stemmed from historical economic and political developments that dictated lasting cultural adaptations.

An anthropologist considering history must attempt a synthesis of theoretical issues in both fields, including issues of the importance of the culture concept, holistic approach, idiographic vs nomothetic foci, and diachronic vs synchronic analyses. Anthropologists have been criticized for harboring ahistorical tendencies. In the early 20th-century they defined their purpose as the description and documentation of current sociocultural life cross-culturally. They rejected as too speculative previous attempts to explain the historical evolution and diffusion of cultural forms (Kroeber 1935; Boas 1936; Vidich 1966; Lévi-Strauss 1967; Harris 1968; De Waal Malefijt 1974; Langness 1974).

Social anthropologists studying structures and functions of societies in Africa, Asia and elsewhere were later accused of being antihistorical. It has been argued that they succumbed to the "fallacy of the ethnographic present" in ignoring the significance of historical and social change under the especially controversial conditions of European colonialism. In their defense was the reality that most of the small societies they studied had no written traditions. Nevertheless, a synchronic focus be-

came dominant not only in the field of anthropology but in sociological studies of Western society as well (Radcliffe-Brown 1952; Evans-Pritchard 1961; Schapera 1962; Thomas 1963; Lewis 1968, quoting M. G. Smith; Asad 1973; Frank 1979).

History appears formally in anthropology as the field of ethnohistory. It was necessary to document the acculturation of American Indians using historical materials to supplement fieldwork observations. In conventional anthropological fashion, ethnohistorians give equal weight to oral traditions as to documentary evidence. They have expanded their work to other societies as well (Sturtevant 1966; Euler 1972; Wylie 1973; Schwerin 1976). Independent anthropologists have also produced excellent historical studies (Balandier 1969; Wallace 1978; Wolf 1982).

In many cases both social and cultural anthropologists conducted at least partial historical studies of the societies with which they were concerned. But none achieved the sophistication of French social historians of the same time period. Members of this Annales school of social history were chiefly concerned with mentalité or culture. They attempted especially to document the ordinary life and popular attitudes and values of social experience (Forster and Ranum 1975). Thus they conducted historical research with an essentially anthropological focus.

A corollary of the imputed ahistoricism in anthropology has been a strong reliance on a natural science model, an empiricist and quantitative methodology. Anthropology has not benefitted from exposure to the humanistic, idiographic, and idealist position of many historians. Instead, they have emulated sociology for its nomothetic, generalization-seeking paradigm. Many historians have also felt that it was necessary to make history more scientific and have introduced rigorous methods of quantifica-

tion and statistical analysis. These approaches tend to be based on an assumption of value-freedom in social research that cannot be supported. Interpretation is needed for explanation in both history and anthropology, and it will always entail value judgments. It is doubtful that the hypothetico-deductive model will ever produce historical or anthropological "laws" of human behavior (Mills 1959; Carr 1961; Anderle 1964; Fox-Genovese and Genovese 1976; Vann 1976; Cohn 1980).

Traditionally histories of medicine have been narrow studies of medical men, practices, and institutions. Some medical historians such as Henry Sigerist, George Rosen, and Charles Rosenberg have brought a sociological perspective to their study and call for examination of what actually happened to people in the history of health and disease. But the primary framework for interpretation in medical history has been one assuming a progressive development in scientific knowledge and "conquest" of disease. Thus it has been an iatrocetric history of our own folk model of biomedicine. Medical anthropologists and medical historians have equally come under the spell of our own cultural model, providing little in the way of alternative interpretive work. But more medical historians are now calling for a sociocultural approach (Rosen 1967; Rosenberg 1971; Temkin 1971, 1977; Eisenberg 1977: 73; Engel 1977; Grob 1977; Brieger 1980).

This dissertation reflects a syntheistis of literature from both anthropology and history, but it depends upon primary materials selected from popular and professional documentation of 1870s San Francisco.

#### Mode of Presentation

My aim in this dissertation is to apply the theoretical perspective of medical anthropology historically. I chose to study the decade of

the 1870s in San Francisco because it was a time period just before substantial changes took place in the history of medicine in this country. Not only was this decade just prior to the discoveries of bacteriology, but it was also a time before the regular medical profession had consolidated its power and authority. Those who were the forerunners of today's physicians did not yet have greater status than many alternative practitioners. Much of the public regarded them as simply one of several medical sects. Thus San Francisco in the 1870s presented a situation in many ways similar to that in Third World countries today where both Western scientific medicine and industrialization are newly introduced to compete with indigenous medical systems. As we have seen, there is an analogy as well to present-day San Francisco where ambiguity in disease definitions has resulted in an efflorescence of alternative therapies. Medical anthropological concepts and theoretical perspectives have been developed and tested in situations of medical pluralism. If we wish to discover universal generalizations about the cultural construction of health and disease, such concepts should "work" historically as well.

I concentrate on what we call infectious diseases today because they were responsible for much of the mortality of this period and were the subject of etiological and therapeutic debate. These diseases created an ambiguity in the social construction of disease and its treatment analogous to that of chronic disease today. Both situations resulted in growth and spread of a variety of medical ideologies and therapeutics, many of which exist today little changed from a century ago. San Francisco experienced later in the 19th-century the social and economic disruption accompanying industrialization, urbanization and immi-

gration. The conjunction of these forces in the 1870s with the insecure state of competing medical systems which could neither successfully explain nor treat infectious diseases created a social situation ideal for anthropological analysis. It clearly presented a situation of needed fieldwork.

My aim throughout this work is to present the viewpoints of ordinary people who suffered from infectious diseases as well as the perspectives of those who treated them. I regard the regular profession in the same terms as its competitors; and do not attempt to write a history of that group. But it is easy to fall into the trap of ethnocentrism or iatrocen- trism in medical historians' terms, and present the perspective of the medical profession as central to the examination of medical ideas. Part of the reason for this is that they have left more historical evi- dence in their professional journals, publications of medical societies, and official documents. In anthropological terms, these physicians have presented themselves as key informants. It is a common anthropological experience to be led astray by members of the community who eagerly put themselves forward as interpreters of their culture. A balanced analysis requires seeking information from those most reluctant or unable to provide it. In historical research one is defeated in this quest because the illiterate poor and ethnic immigrants have remained largely inarticulate, leaving us only indirect evidence of their experiences.

I follow the model of ethnographic research by describing the social and economic setting of 1870s San Francisco in the first few chapters. For this description I rely largely on secondary sources, although I use primary materials to get a sense of how San Franciscans themselves felt about life in their city in the 1870s. These chapters set forth the



larger social forces that were interacting to create infectious diseases in San Francisco. Conditions of public health in all American cities produced "fever nests" of disease.

In the remainder of Part One I try to unearth the hidden experience of those who left no written accounts by examining its reflection in the commentary of contemporary observers. Members of the regular medical profession took on the responsibility of documenting the public health of San Francisco statistically. I report both their interpretation and my own of what their statistics reveal about the underclass of the city. Health officers emphasized certain social forces as responsible for infectious disease. They regarded these causes as aberrations in an otherwise healthy city. In reality disease statistics reveal that the foreign-born and especially their children were the victims of infectious diseases. Health officers realized this by the end of the decade and began to regard this population as aberrant as well.

Part Two tackles the regular medical profession, its ideology and therapeutics. Excellent historical and sociological studies of the 19th-century profession are available, to which I refer. My effort here has been to present this group as one of several ideological forces competing for medical practice in 1870s San Francisco. Part Three discusses popular and sectarian alternatives including the well-established professional medical groups of homeopaths and eclectics. The ethnomedical division of medical practice into professional, popular, and folk sectors breaks down at this point because it does not provide for competing but equally professional sects. In this section I also discuss the very popular and common alternative of patent medicines available to 1870s San Franciscans. Again, while such therapeutics might be considered part

of a popular sector, they are also a folk tradition. I discuss the reaction of the regular physicians to these competitors in Chapter Twelve. It was necessary for physicians to discredit their rivals to gain the legitimacy they retain today. By the end of the decade they had succeeded in gaining sufficient cultural authority to see a state medical law passed defining and limiting medical practice. But their professional rivals were still prominently included on separate boards of examiners. The controversies surrounding enactment of this first law resonate today as Californians again debate the regulation of medical practice and regular physicians object to the competition and dangers of "quackery".

Part Four addresses the folk medicine alternative that continued to exist as well as the therapeutic approach of climatotherapy, which crossed the boundaries of professional, popular and folk sectors. That this three-part classification is an etic category is evident; for ordinary people might equally resort to any one of these alternatives, or to all of them. I present evidence from letters and diaries that illustrates people's use of regular medicine and all its alternatives. This evidence indicates clearly that what people suffered was illness, not disease. Often they did not even use contemporary disease names, but simply reported themselves ill. The common conception of the human body was one in which symptoms were illness; and they might be treated in a number of different ways. Specific etiologies and specific disease entities were often identified neither by physicians nor their patients. Illness makes social sense only if we embed it in a particular contextual reality such as this.

## Endnotes for Introduction

<sup>1</sup>"A disease caused by a specific, pathogenic organism and capable of being transmitted to another individual by direct or indirect contact" (Livingstone's Pocket Medical Dictionary). The term "communicable" is sometimes preferred.

## PART ONE: SETTING AND CIRCUMSTANCE

### CHAPTER ONE: "GAUNT MISERY STALKED THE STREETS":

#### THE SOCIAL SETTING OF 1870s SAN FRANCISCO

##### Economics

By the 1870s many, if not most San Franciscans reassessed their expectations in migrating to this place. Almost all had come for economic improvement in their lives, if not to "strike it rich". They came with the Gold Rush and for the silver mines. Or they came to profit from serving the needs of other immigrants. Huge numbers of them left when their quests failed. Few felt any civic responsibility to build a community in San Francisco's first decades.

It was nonetheless unavoidable that great economic and population changes would create an urban society there. Very few who stayed acquired great wealth. Many found themselves worse off than before. Initially in the 1850s and 1860s skilled laborers were needed to serve the new entrepôt. San Francisco became the trade center and freight handler of the West Coast. Several organizations were founded by local businesses to encourage immigration of "the right sort" (Shumsky 1972: 33; Cherney and Issel 1981: 11-13, 26-27).

Even as these efforts took place the economic realities of the city were changing. Industrialization here as elsewhere altered the nature of work. Skilled artisans and craftsmen were less needed than were unskilled machinery operators. The labor supply increased, as did competition for jobs and unemployment. Completion of the transcontinental railroad in 1869 aggravated the situation. Great numbers of people migrated to San Francisco on trains from the East, and many others released from rail-

road construction came to the city for work. Production in the Nevada silver mines failed because of fires and floods; so miners also retreated to the city. After 1870 chronic unemployment became a social problem (Scott 1959; Shumsky 1972, 1976; Lawrence 1979).

Great millionaires grew enormously rich building the Central Pacific Railroad. Expected economic benefits to the community from the railroad did not materialize, however. Its completion exposed a previously isolated community which had set its own prices and wages. The city now faced competition from the rest of the country. Eastern goods became available and San Francisco no longer controlled a strictly Western trade network. The full weight of a national business cycle was now felt on the West Coast.

The millionaires profited; the city did not. As the decade of the 1870s began San Francisco suffered financial depression and unemployment. A drought had disastrously affected agricultural profits. The stock exchange fell because it had been "chronically overstimulated by silver stock speculation" (Cole 1981: 76-77).

In 1873 a month-long financial panic took place in the United States, followed by a depression that lasted until 1877. The Bank of California failed in San Francisco in 1875. About one-fourth of the approximate 150,000 new arrivals in California between 1873 and 1875 were unskilled laborers. Resulting unemployment in the context of economic slump created "widespread destitution" (Young 1912; Scott 1959; Shumsky 1972; Decker 1978; Cole 1981).

Figures on unemployment were unreliable, even as they are today. Some estimated that twenty per cent in the state were out of work. Charities in San Francisco reported that they were feeding many people

(Shumsky 1972: 53, 118-119). Frequently people were only semi-employed, unable to support families, and lacking in all but the essentials for existence.

Unskilled laborers were not the only ones who suffered during this period. Merchants and businessmen suffered three times as many bankruptcies in the 1870s as they had in the previous decade. Earlier merchant businesses were taken over by "slaughtering, meat packing; sugar refining; boots and shoes; foundries; machinery; men's clothing; tobacco and cigars" (Decker 1978: 237-239, 167, 177). Occupational mobility declined. Opportunities for blue collar workers to enter the white collar class had been greater in the 1850s. The "rags to riches" mythology of the early city no longer had even a pretence of substance.

Economic chaos in 1870s San Francisco meant few opportunities for new arrivals. According to U.S. Census figures, 67 per cent (45,872) of the employed in San Francisco in 1870 were foreign-born. In 1880 64 per cent (67,181) of the total with occupations were foreign-born. These figures mean that 46 per cent of the city's population was employed according to the 1870 census, and 45 per cent in 1880, with about two-thirds of them foreign-born each year. Irish-born workers made up the largest number (22 per cent of total employed in 1870, 16 per cent in 1880). They concentrated in key occupations of domestic servants and laborers (United States Census 1872: 799; 1883: 855, 902; see also Larsen 1978: 36-39).

Other ethnic differences in occupation existed. Germans, often Jewish, tended to be merchants. Italians were shopkeepers or fruit, vegetable and fish peddlers and dealers. Many Irish were also shopkeepers. Blacks were present at several social levels, both working and

middle class. Some Blacks had Chinese servants. Blacks predominated as barbers in San Francisco until Europeans took these jobs in the 1890s. Blacks maintained residences throughout the city. The Chinese were employed in the clothing and textile industries and as cigar-makers. Other European immigrants worked in "saw and planing mills, sash factories, box factories, foundries, machine shops, gold and silver quartz mills, printing and publishing houses (Parker and Abajian 1974; Muscatine 1975: 115; Shumsky 1976: 46-48; Decker 1978: 159-172).

San Francisco soon developed a distinct class structure, and even the middle class found occupational mobility difficult. Decker (1978) argues that the situation was orchestrated by an elite who controlled entry into the upper classes. An observer in 1881 commented on the newly acquired gentility in the city: "'San Franciscans are beginning to have aristocratic notions....They hint at pedigree, 'old stock,' and talk exclusiveness'" (quoted in Pomeroy 1968: 127).

The unreliable economy and chronic unemployment disillusioned those who had migrated to better themselves. Wages became lower and people worked ten to twelve hour days (Pomeroy 1968: 178). Frank Roney, later a labor leader, wrote of his continual problems in holding down a job. He worked an average ten hour day, and held at least four different foundry jobs from which he was laid off in 1875-76. He later commented on this period that

the number of idle men had daily increased and the number of Chinese had increased also. Gaunt misery stalked the streets. Destitution prevailed everywhere. Bankruptcy, Suicide, and plunder and robberies were the order of the day (Roney n.d.)

The experiences of James Galloway in small towns near San Francisco were also typical. He continually changed jobs during this time of

economic uncertainty. He farmed, bought and sold land, went prospecting, and moved his family a number of times. In 1872 he bought into a grocery store in San Francisco and also dabbled in mining stocks. By the end of the year he felt that both activities were errors. He moved to the Napa Valley in near poverty. Finally he began to work for the Consolidated Virginia Mine in Virginia City and again moved his family. He continued to work in the mines until after his wife's death. He commented in 1879 when he had changed to lumber yard work:

To day I am 45 years of Age after 26 years of struggle  
on the Pacific Coast to build up a home I am a Poor Man  
but with a conscience clear that I am an honest man  
(Galloway 1853-1882: 10/7/1879).

Pessimism was widespread in San Francisco and was augmented by increased illness, suicide, crime, and other urban problems. Immigrants were blamed for these changes and efforts were made to control their entry (Lawrence 1979: 28-39). Many workers found that they could not marry and have children because the cost of living was so high. Roney commented in his diary about his indebtedness:

My wifes anticipated sickness [parturition] is not yet  
arrived which will leave me better prepared for the  
event when it does take place (Roney 1875-76: May 1875).  
These two years past have been a period of great trial  
to my wife and none of us have not felt its effects. So  
hope in God (Roney 1875-76: January 1876).

Even those who found jobs worked long hours under poor conditions. The worst jobs were held by the Chinese, and most of the other lower-paid jobs went to European immigrant workers (Lawrence 1979: 67-72).

The unemployed and under-employed responded to their circumstances by forming the Workingmen's Party of California in 1877, after finding that traditional Democratic Party and church supports had failed them. The latter two institutions were controlled by a fashionable elite.



Members of the WPC were laborers and factory workers. Most were Irish or of other European backgrounds. They shared the capitalists' belief that an excess of new immigration was responsible for employment problems. The Chinese especially were blamed. In the summer of 1877 the WPC engaged in a major street protest, quelled by a vigilante committee (Pomeroy 1965: 179; Miller 1969; Shumsky 1972, 1976; Decker 1978; Lawrence 1979; Cole 1981).

The 1880s brought a more tranquil period to San Francisco. The city stabilized new sources of capital in factories, agriculture, and railroad and shipping industries. They "were years of sober, patient advance, free from the speculative madness, the shattering crashes, and the abject misery of the previous bizarre decade" (Scott 1959: 71).

New arrivals in San Francisco in the 1870s had insight into the economic conditions they observed. For example, William Laird MacGregor, travelling for the Wanderer's Club of Pall Mall in 1876 remarked on San Francisco's high suicide rate and the crowded stock exchange in "this vast gamble for wealth". He felt however, that working men would not suffer if they were "steady" and didn't drink (MacGregor 1876: 29-34, 54). Anthony Trollope similarly commented in 1875 that "the trade of the place, and the way in which money is won and lost, are alike marvellous." Everyone gambled with silver stocks: "The housemaids and others go to the wall, while the knowing men build palaces, and seem to be troubled by no seared consciences"(Trollope 1951: 541-544, orig. pub. 1875).

Rabbi Isaac Wise carried this theme a step further, noting that land, business, and capital were all in the hands of a few, and that there were many poor men in the city (Wise 1967: 12, orig. pub. 1877). Miss Lucy Jones expressed the usual pity of one of her class for poor people

seen at a Union Hall sermon in 1875:

I like these meetings very much. It did seem nice to see so many poor people there taking such an interest in religious matters. There were two men in their overalls. nice looking men but looked as though they were very poor and had to work very hard. They sat beside us and sang away with a will from their singing book. They all feel that they can go to Mr. Hammonds meeting and think nothing of their clothes and feel at their ease. I wish that all the protestant churches gave to everyone that feeling (Jones 1874-75: 4/4/1875).

Several observers commented on the WPC street demonstrations in 1877. Amelia Ransome Neville felt that "a just resentment of white labor against low wage-standards of coolies became the inspiration of senseless violence; and the Sand-Lot Riots resulted." She commended the use of pick-axe handles by the Citizens' Committee to disperse the crowds (Neville 1932: 197-198). Rabbi Wise happened to be visiting San Francisco during the fateful period. He identified the unemployed protestors with San Francisco's "hoodlums", who often attacked Chinese (Wise 1967: 16-19, orig. pub. 1877).

#### Population and Ethnic Composition

The San Francisco Bay Area was a natural magnet to the many immigrants who responded to California's appeal. One young woman later recalled conversations about California she overheard as a small child in Pennsylvania. Her mother, "who was very delicate, though not really ill, said very little but she looked very queer when anyone spoke that name." Various friends and relatives, including her father, began to study maps. Her parents did not discuss her father's plans with the children,

But something was in the air. I felt it without seeing it or hearing and I connected it with a trunk that had been brought out and packed at night. My mother looked pale, and my grandmother stepped about much more quickly

than usual and her chin was lifted high. She wouldn't look at anyone (D'Apery 1852-1872: 116-119).

In spite of this resistance, her father left for California. The rest of the family joined him in Oakland several years later, just after the great San Francisco fire of 1852.

Many such travel accounts might be cited to illustrate the great East to West population movement. California's population increased by over half a million between the Gold Rush and 1870. Most immigrants were men born elsewhere in the United States (Wright 1941: 73-74). The primary inducement was the promise of economic betterment. Those whose dreams had failed elsewhere migrated West for new possibilities.

The nine counties of the San Francisco Bay Area especially felt this population increase. Population there gained 133 per cent between 1860 and 1870. During this same decade the state gained 47 per cent in population. Half the people in the state lived in the Bay Area in 1870, and a quarter of them in San Francisco. The city's population almost tripled between 1860 and 1870 (Scott 1959: 50).

San Francisco was the fifteenth largest city in the country at the beginning of the Civil War (population according to the U.S. Census of 1860 was 56,802). The city population grew 160 per cent in the Civil War decade, and 56 per cent in the 1870s (population in 1870 was 149,473). By 1880 it had become the ninth largest city in the United States, with a population of 233,959. Not only was there a phenomenal growth in population during these two decades, but it was a dynamic movement, with much turnover among unskilled manual laborers (Decker 1978: 171; Andriot 1980: 67, 76; Cherney and Issel 1981: 10).<sup>1</sup> Most of the new arrivals continued to come by sea, "a terrible trip...around Cape Horn in a sailing ship," or over the Panama route. About 20,000 people

arrived in San Francisco in these ways in 1870, 70,000 in 1873, and 85,000 in 1874. In 1875 an equal number came by train, about 75,000 people (D'Apery 1852-1872: 125; Scott 1959: 62).

Because of this dramatic change in population, actual figures were very contradictory. The uncertainty about total population figures becomes important in the calculation of death rates for this period. Most commentators refer to official U.S. Census figures for the city; but these were always considerably lower than figures produced by city directories (Table One).

Federal officials admitted to census defects (U.S. Census 1872: xlvii, xix-xxv). The 19th-century as a whole was a frustrating time for those who could foresee the census as a mechanism for information gathering. European census figures were used to determine public policies. But the United States did not recognize this function of a federal census. Instead the census was used to determine political representation only. Early censuses did attempt an inadequate enumeration of the deaf, blind, illiterate, feeble-minded and insane. But counts of vital events (births and deaths) begun after 1850 were almost worthless (Cassedy 1965: 222; Grob 1976: 4-5).<sup>2</sup>

The editor of the city directory commented that problems of the 1870 census in San Francisco included

the refusal of a number of persons to give their names for publication....in addition to this class, there are a number who escape the canvass altogether, and a large foreign element that does not speak the English language. These, together with a considerable number of persons residing in disreputable neighborhoods, aggregating over 3,000, should be included as a part of the permanent population....These figures do not include a class of persons residing in the city, usually called "floating" (Langley 1871: 13).

TABLE ONE: POPULATION FIGURES, SAN FRANCISCO 1869-1880

<u>YEAR</u>	<u>SOURCE</u>		
	<u>City Directory</u>	<u>Health Officer</u>	<u>U.S. Census</u>
1869	170,000		
1870		150,361	149,473
1871	172,750		
1872		186,000	
1873		185,000	
1874	200,770		
1875	230,000		
1876		280,000	
1877		300,000	
1878		300,000	
1879	330,000		
1880	305,000		233,959

This explanation accounts for the consistently higher city directory than federal census figures. It also suggests how unreliable health statistics for the city were during the 1870s. Of particular interest to the study of infectious diseases during this decade is just this immigrant and foreign-born group. All new San Franciscans experienced the hardships and privations of migration and fell victim to consequent diseases. But the foreign-born were isolated by cultural and language handicaps, poverty, and discrimination, so that they always appeared heavily in the lists of ill and dead.

As San Francisco first settled between 1850 and 1860 about half its population had foreign birthplaces, compared to one in ten residents of the United States generally. The city occupied third place in the country as an immigrant center in 1860 (Cherney and Issel 1981: 10). Table Two shows the actual nativity of San Francisco's foreign-born population in 1870 and 1880, according to census schedules. The foreign-born composed 49 per cent (73,719) of the city's population in 1870, and 45 per cent (104,244) in 1880. The largest number of immigrants were from Ireland, China, and the German states (U.S. Census 1872: 386-391, 598; 1883: 538-541). The percentage of foreign-born in the overall Pacific region of the country was only 3.1 per cent in 1870; while it was 34.1 per cent in the Middle Atlantic region (Ward 1971: 51, 67). Thus San Francisco's population composition was unusual.

Figures on the foreign-born in the city reflect only the first generation of immigrants. In addition during the decade of the 1870s second and third generation people of foreign heritage were taking their places in San Francisco social life. Even as late as 1910 68 per cent of the city's population was foreign-born or had a foreign-born parent (Wollenberg

TABLE TWO: NATIVITIES OF FOREIGN-BORN,  
SAN FRANCISCO, 1870 and 1880

<u>YEARS</u>	<u>BIRTHPLACES</u>							
	<u>Not Stated</u>	<u>Africa</u>	<u>Asia</u>	<u>Atlantic Islands</u>	<u>Austral-Asia</u>	<u>Austria</u>	<u>Belgium</u>	
1870	3	25	20	164	914	476	139	
1880		35	3	54	1,097	765	175	
	<u>Bohemia</u>	<u>British America</u>	<u>Central America</u>	<u>China</u>	<u>Cuba</u>	<u>"Europe"</u>	<u>France</u>	
1870	43	2,337	74	11,729	28	3	3,547	
1880	149	3,860	96	21,213	27	39	4,160	
	<u>German States</u>	<u>Gibraltar</u>	<u>England</u>	<u>Ireland</u>	<u>Scotland</u>	<u>Wales</u>		
1870	13,602		1	5,172	25,864	1,687	247	
1880	19,928		3	7,462	30,721	2,243	333	
	<u>"Great Britain"</u>	<u>Greece</u>	<u>Holland</u>	<u>Hungary</u>	<u>India</u>	<u>Italy</u>	<u>Japan</u>	
1870	28		27	190	61	17	1,622	8
1880	13		64	292	128	42	1,995	5
	<u>Malta</u>	<u>Mexico</u>	<u>Pacific Islands</u>	<u>Poland</u>	<u>Portugal</u>	<u>Russia</u>	<u>Sandwich Islands</u>	
1870	2	1,220	57	517	199	281	51	
1880	23	292	8	72	75	76	9	
	<u>Scandinavia</u>	<u>South America</u>	<u>Spain</u>	<u>Switzerland</u>	<u>Turkey</u>	<u>West Indies</u>	<u>Greenland</u>	
1870	1,763	418	119	775	7	207		
1880	1,203	24	797	452	8	423	1	
	<u>Luxemburg</u>	<u>At Sea</u>	<u>Total Foreign-born</u>			<u>Total Population</u>		
1870		75	73,719			149,473		
1880	5	28	104,244			233,959		

PERCENTAGE IRISH, GERMAN, CHINESE OF TOTAL POPULATION

	<u>Irish</u>	<u>German</u>	<u>Chinese</u>
1870	17.3	9.1	7.8
1880	13.1	8.5	9.1

Source: United States Census 1872: 386-391; 1883: 538-541.

1971: 222).

The largest number of foreign-born immigrants to San Francisco was from Ireland. In spite of their relatively high turnover rate in the early years of the city, the Irish proportion of the city population remained the same through the 1860s and 1870s. Many had originally settled on the East Coast (Wright 1941, Part II: 65; Burchell 1976: 304; Decker 1978: 171). In 1880 the Irish were the largest ethnic group in San Francisco according to their chronicler, Robert Burchell. He argues that Irish composed a third of the city's population in 1880 if second, third, and fourth generations are included in the count (Burchell 1980: 3-4). Immigrants from the German states were nearly as large a proportion of San Francisco's population, but they were a less homogenous community, divided by religious and cultural differences (Cherney and Issel 1981: 29). The Chinese presence in San Francisco has received much attention. In 1852 Chinese comprised less than one per cent of the population, eight per cent in 1870, and nine per cent in 1880 (Decker 1978: 171; Trauner 1978: 72).

Another important characteristic of the San Francisco population to keep in mind when considering health statistics is that the city was predominantly both male and young. In 1870 the large majority of the population was under fifty. At the city's beginning males over 21 outnumbered such females 6.5 to 1. By 1860 this figure had changed to 2.5 to 1, with far more native-born than foreign-born females. Women comprised about 40 per cent of the city in the mid 1860s. By 1870 over 57 per cent of the city was male and in 1880 they were 56.7 per cent of the population. The sex ratio in 1880 was about equal for people under 29. For the older population it remained about three to



two (Muscatine 1975: 140; Decker 1978: 211; Lawrence 1979: 64; Cherney and Issel 1981: 11). These differences reflect the birth of female children in the city. A population of recent immigrants such as this also tends to be healthy, for unhealthy people rarely migrate.

The significance of these population characteristics for death rates of women and children must be kept in mind. Additionally, the relative absence of families had an impact on the nature of social life during this period. A visitor to San Francisco in 1869 wrote that

There are probably more bachelors, great lusty fellows, who ought to be ashamed of themselves, living in hotels or in 'lodgings' in this town, than in any other place of its size in the world. There is a want of femininity, spirituality in the current tone of the town; lack of reverence for women; fewer women to reverence, than our Eastern towns are accustomed to....'a town of men and taverns and boarding houses and billiard-saloons' (Bowles 1869 quoted in Cook, Gittell and Mack 1973: 30).

By 1870 San Francisco was increasing in average family size. The average number of children per couple went from 2.5 in 1852 to 3.2 in 1880; average family size from 4.9 in 1870 to 5.4 in 1880 (U.S. Census 1872: 598; 1883: 671; Decker 1978: 212, 315). These changes reflected increase in numbers of children people had as they grew older.

Households and family units of the foreign-born were somewhat larger than those of the native-born. The Irish-born population was unusual in having always migrated with their families. Perusal of the 1880 manuscript census schedules confirms this picture. Irish laboring families often had older children born in New York, Michigan, Nevada, and other states along the migration route, and younger children born in California. Census data poorly reflect the dynamic nature of living arrangements, especially among poor people. But the 1870 census suggests that Irish had relatively small families, in spite of their Catholicism.

It shows an average 2.3 children in Irish families. As we shall see, Irish wards reported the highest death rates from infectious diseases, so child mortality may explain the small Irish families of 1880. There was also a deliberate effort to limit family size by this time. (Decker 1978: 325; Burchell 1980: 73, 87).

### Summary Chapter One

As San Francisco became an industrial city in the 1870s, the labor supply of unskilled workers increased to the point of chronic unemployment. Completion of the transcontinental railroad increased immigration to the city, both from the East and among unemployed railroad workers. Economic speculation in gold and silver mining was widespread and the railroad did not bring expected economic boons. The decade began with financial depression and growing destitution of the city population. Rather than understanding the economic forces at work, San Franciscans resorted to blaming each other. Those who had been in the city longer blamed the competition of incoming immigrants. Previous foreign-born immigrants accused the Chinese of disrupting the employment picture by working for low wages. The San Francisco establishment blamed the largely immigrant Workingmen's Party for disruptions. The WPC blamed the capitalists. The city began to participate in class warfare.

The economic situation was aggravated by the city's exponential growth in population, making it the ninth largest city in the country by 1880, and vastly larger than any other Western city. The population was also largely transient and male. There was so much movement that census counts are quite unreliable. Almost half the city population was foreign-born during the decade of the 1870s. These men (and women) composed the

majority of the city's work force. During the decade of the 1870s more families settled in San Francisco and more children were born to the relatively young population. Immigrants to San Francisco were not rural innocents. Almost all had lived previously in cities and towns elsewhere in the country. But none had before experienced the impact on living conditions of late 19th-century urbanization and industrialization.

#### Endnotes Chapter One

<sup>1</sup>My efforts to trace working class Irish families from 1870 to 1880 using the manuscript federal census were largely unsuccessful, presumably because these families had moved to other states, or had somehow not been enumerated in 1880. The "Soundex" system makes it possible to trace an individual by name in 1880 if his or her household included children under the age of ten.

<sup>2</sup>Dr. Edward Jarvis was influenced by European use of vital statistics in the 1840s. He spent a lifetime attempting to improve the United States Census so that it might provide social and medical statistics. But his frustrating work was at an end by 1870. John Shaw Billings introduced the concept of registration area in 1885, to improve the collection of vital statistics. But neither death nor birth registration was really seriously attempted until well into the 20th-century. It was only then also that the medical profession showed an interest in them (Cassedy 1965, 1969; Grob 1976, 1978).

## CHAPTER TWO: "THIS STRANGE, PUZZLING FOREIGN COMMUNITY"

Immigrant Settlement

San Francisco was known as a "hotel" city among the upper classes. But almost everyone lived in lodgings, regardless of class level.<sup>1</sup> Among the wealthy it was fashionable to live permanently in palatial hotels. Middle class clerical and professional workers also lived in good hotels or lodgings and took their meals at restaurants. People with less money might stay at the "What Cheer House" for fifty cents a night, a hotel known for its cleanliness and high standards. It catered especially to miners and mechanics who were surprisingly literate, and made good use of the hotel library. They also had their clothes washed and mended there (Van Orman 1969: 7-8; Cook, Gittell and Mack 1973: 30-31).

In 1875 twenty principal hotels were listed in a guide to the city. In 1876 there were five upper class hotels (The Palace, Lick House, Cosmopolitan, Grand, Occidental), sixty-three smaller hotels, and 254 boarding houses, according to a British visitor. Some families occupied elegant suites in the fine hotels of ward five, "fitted up as luxuriously and comfortably as their own house would be; all their 'Lares and Penates' around them". Such a suite with board cost between \$150 and \$1,000 or more per month. It was nonetheless considered less expensive than maintaining one's own home because of the problem of finding servants, according to this observer (MacGregor 1877; The Stranger's Guide 1875).

Anthony Trollope found hotel life in San Francisco uncomfortable in 1875; but over fifty per cent of those staying in hotels lived in them permanently. The average good hotel charged four dollars a day for a room and bath and three meals on the "American Plan". This meant that

meals were taken at set hours at a central table, and not cooked to order (MacGregor 1877: 27, 41; Trollope 1951: 542, orig. pub. 1875; Van Orman 1969: 14). The kind of hotel in which one lived became a measure of social status in this rapidly stratifying town. Samuel Williams wrote in 1875 that

Living at a first-class hotel is a strong presumption of social availability, but living in a boarding-house, excepting two or three which society has endorsed as fashionable, is to incur grave suspicions that you are a mere nobody. But even in a boarding-house the lines may be drawn between those who have a single room and those who have a suite (quoted in Lewis 1962: 193).

This way of living provided companionship and social life for lonely single men. In some cases women were alone. In 1868 Sallie Snow wrote her sister about her life with her small son waiting for her sailor husband's return to the city. She lodged in the same house for six months. Eating in her favorite restaurant twice a day provided her only outings. She clearly enjoyed her breakfasts of "Broiled quail, beef-steak, butter toast, and Buck wheat Cakes" for 37½ cents (Snow 1868: 5/27; 11/21).

The immigrants and foreign-born who settled in San Francisco tended to live in certain neighborhoods by necessity as well as by choice. San Francisco did not develop the ghettos of eastern cities, but as in those cities the working poor tended to live near the central business district. Their employment was insecure and changing and they needed to be near the source of new jobs. Most could afford only to walk to work. Many worked as peddlers and needed to be in the market area (Ward 1971; Shumsky 1972: 138).

These neighborhoods had initially been one of the most elegant areas of the city (recently proposed in 1983 for re-gentrification). They included South Park, Happy Valley and Rincon Hill. With the development

of cable cars in the 1870s the well-to-do moved to the Western Addition of ward twelve.<sup>2</sup> Harriet Lane Levy recalled how her father and other Jewish businessmen left the area and built homes in newer parts of the city (Levy 1975: 2-3; orig. pub. 1937).

The wealthy who moved to Stockton, Bush, Pine, Powell, and Mason streets continued a life in which they "housed a bevy of house servants, cooks, Chinese launderers, coachmen, and footmen". Middle class homes were visited by bakers, fish-mongers, grocers, butchers, laundrymen and vegetable vendors of many ethnic backgrounds. Middle class people could afford to live farther from the business district because of these services, and because they had the money and leisure to commute to their workplaces. The native-born population of the city (who tended to be the middle class) commuted a thirty per cent greater distance to work than did the foreign-born. Many began to settle across the San Francisco Bay in Berkeley, Oakland and Alameda, travelling by ferryboats, the traffic on which doubled in the 1870s. The better-off working class also began to move away from the business district, along Mission, Howard, Folsom and Harrison streets from east to west (Scott 1959: 63; Levy 1975: 196, orig. pub. 1937; Decker 1978: 215, 227).

In the middle of the decade the most densely populated wards in San Francisco were those of Chinatown (wards four and six). The next most densely populated were wards ten, three and five located near the waterfront and north and south of the Market Street business district. Wards seven and eight, in the same general areas, also had high densities. These seven heavily populated wards accounted for 58 per cent of the city's population in 1876 (Table Three).<sup>3</sup> The South of Market area (including ward ten and parts of wards seven, nine and eleven) became both

TABLE THREE: SIZE AND POPULATION OF SAN FRANCISCO WARDS, 1876

<u>WARD</u>	<u>ACREAGE</u>	<u>POPULATION</u>	<u>%</u>	<u>PERSONS PER ACRE</u>
1	165	13,974	( 4.8)	84.7
2	385	14,436	( 5.0)	37.5
3	67	7,782	( 2.7)	116.1
4	128	33,763	(11.6)	263.8
5	52	6,019	( 2.1)	115.8
6	133	25,945	( 8.9)	195.1
7	177	17,667	( 6.1)	99.8
8	291	30,211	(10.4)	103.8
9	361	19,406	( 6.7)	53.8
10	258	46,010	(15.8)	178.3
11	21,717	45,578	(15.6)	2.1
12	4,470	30,568	(10.5)	6.8
		<u>291,359</u>		

(SOURCE: San Francisco Chronicle 1/23/1877, XXV(8): 3)

the industrial area of the city and the major residential neighborhood for the immigrant working class and the unemployed.

Living conditions varied in the South of Market area. Immigrants did not live in the type of tenement houses found in large eastern American cities. Many San Francisco newcomers lived in single rooms of houses abandoned by wealthier residents as neighborhoods changed in character. Such buildings became lodging and boarding houses (the latter provided board as well as room). Or they lived in the upper floors of commercial buildings, much as do artists and other marginal income people in this same neighborhood today. As time went on immigrant housing deteriorated under pressure from rapid population increase. Most housing was inadequately built of wood and hazardous. Overcrowding became a serious problem, as it was in all 19th-century cities. Poor water and sewer facilities produced disease that was often blamed on the immigrants themselves. In 1879-80 ward ten and part of ward eleven contained one-half the city's 655 lodging houses, one-third its boarding houses, one-fourth of the hotels, and one-third of 250 listed restaurants. There were many specifically ethnic hotels (Van Orman 1969: 7-8; Averbach 1973: 201; Lawrence 1979: 33-36, 72-73; Burchell 1980: 39, 44).

Sallie Snow found her hotel life south of Market Street in 1868 especially lonely because she felt a social distance from her neighbors:

there being none that I care to cultivate in the immediate vicinity...all Irish or German though of a good class. but Catholic or Jews. Very respectable quiet neighborhood but of course I cannot be intimate with any of them (Snow 1868: 11/21).

She appreciated her neighborhood however, because it had a pleasant bay view and was regarded as safer from fires, earthquakes and smallpox.

Kate Douglas Wiggin opened her kindergarten in this area in the 1870s,



and commented later that

To the ordinary beholder it might have looked ugly, crowded, sordid, undesirable....The activities in plain sight were somewhat limited in variety, but the signs sported the names of nearly every nation upon the earth. The Shubeners, Levis, Ezekiels, and Appels were generally in tailoring or second-hand furniture and clothing, while the Raffertys, O'Flanagans, and McDougalls dispensed liquor. All the most desirable sites were occupied by saloons, for it was practically impossible to quench the thirst of the neighborhood. There were also in evidence barbers, joiners, plumbers, grocers, fruit-sellers, bakers, and vendors of small wares, and there was the largest and most splendidly recruited army of do-nothings that the sun ever shone upon. These forever-out-of-workers, leaning against every lamp-post, fence-picket, corner house, and barber-pole in the vicinity, were all male, but they were mostly mated to women fully worthy of them, their wives doing nothing with equal assiduity in the back streets hard by.--Stay, they did one thing, they added copiously to the world's population (Wiggin 1923: 108-109).

Wiggin's ethnic and class prejudices, expressed in an effort to be humorous, were usual attitudes in the 1920s when she wrote, and in the 1870s when she experienced them.<sup>4</sup> Still, her first-hand view of the social nature of San Francisco in this period is valuable. Her job was to teach the children of this "strange, puzzling, foreign community, this big mass of poverty-stricken, intemperate, overworked, lazy, extravagant, ill-assorted humanity leavened here and there by a God-fearing, thrifty, respectable family" (Wiggin 1923: 111). In this self-contradictory description, she revealed her own poor understanding of these people. In spite of her anti-Semitism however, Wiggin was able to sympathize with little Jacob who was

one of ten children, the offspring of a couple who kept a second-hand clothing establishment in the vicinity. Mr. and Mrs. Lavrowsky collected, mended, patched, sold, and exchanged cast-off wearing apparel, and the little Lavrowskys played about in the rags, slept under the counters, and ate Heaven knows where (Wiggin 1923: 122-123).

The reality of such urban scenes may explain the huge popularity of Charles Dickens in America during this period. He both romanticized and humanized the life of the poor.

Similar to Wiggins' point of view was that of Amelia Ransome Neville, who lived a fashionable life in San Francisco. For example, she said of this period that,

Chinatown was a really exciting place. It was thrilling even in smallpox epidemics when the police guarded all entrances and yellow plague flags were flying over the quarter. But for all the lack of sanitation and bland disregard for Western ideas of law and order, San Francisco never resented its presence. It was<sup>5</sup> too fascinating in its life and color (Neville 1932: 197).

This romantic view of the "color" of ethnic life was commonly expressed by those who regarded immigrants simply as features of the city's cosmopolitan tone. For example, Samuel Williams wrote in 1875 that, "Nowhere else are witnessed the fusing of so many races, the juxtaposition of so many nationalities, the Babel of so many tongues. Every country on the globe, every state and principality, almost every island of the sea, finds here its representative" (Williams 1921: 15). At the same time, Williams had the illusion that the working class in San Francisco was "exceptionally prosperous," and that many owned their own homes. He agreed with Wiggins about the "forever-out-of-workers". Anyone who did not work was popularly known as a "bummer", "a worthless fellow, too lazy to work, too cowardly to steal....The climate befriends him, for he can sleep out of doors four-fifths of the year, and the free lunch opens to him boundless vistas of carnal delights" (Williams 1921: 17, 19).<sup>6</sup>

Rabbi Isaac Mayer Wise commented after his visit to San Francisco in 1877: "An Irish woman told me to-day the same

old story of husband dead, four children, no bread in the house, had not a bite to eat today, etc., and all that for one dime" (Wise 1967: 12, orig. pub. 1877).

During the decade of the 1870s San Francisco began the process of settlement in which families appeared and neighborhoods took on particular characters. Construction of housing did not keep up with the level of immigration and increase in families. Overcrowding resulted and led to disease. By 1880 the number of persons to a dwelling according to the U. S. Census had increased to an average 6.86, and persons to a family to an average 5.38 in San Francisco. These were among the highest figures in the country. In 1870 the figures for San Francisco had been 5.77 and 4.89, respectively (U.S. Census 1872: 598; 1883: 671; Decker 1978: 212). The foreign-born, in spite of efforts to limit their family sizes, still had larger families than the native-born.<sup>7</sup> Peter Decker (1978) has calculated that native-born merchants in 1880 San Francisco had an average household size of 6.4 people and family size of 2.8; while foreign-born merchants had an average household of 6.0 people and family of 3.4 (Decker 1978: 317). The larger household of the native-born may have been because of the presence of servants or boarders. The significance of boarding to family arrangements in 19th-century America is a subject only recently investigated by historians and social scientists (Modell and Hareven 1973; Katz 1975).

The Irish were probably most representative of the problems of immigrant adjustment to San Francisco in the 1870s. They composed the largest percentage of the foreign-born population; they appeared most frequently in morbidity and mortality statistics; they made up large numbers of the unemployed and members of the Workingmen's Party; they

lived in South of Market neighborhoods; and they were settled with families including small children. They were also most likely, after the Chinese, to be targets of discrimination.<sup>8</sup>

By 1870 the Irish lived in the first, seventh, ninth, tenth, and eleventh wards of the city, especially in the seventh, which was along the waterfront south of Market Street. During the decade of the 1870s they moved into the ninth and eleventh wards to the south and west, but their population remained most dense in the seventh. Forty to fifty per cent of the South of Market area was of Irish parentage in 1880, compared to twenty per cent north of Market Street. Perusal of the manuscript U. S. Census for both 1870 and 1880 reveals many Irish-born in ward seven, although the American-born predominate. Occupations in the ward are those of laborers and various working class employments, including a number of female Irish servants. Ward eleven reveals Irish grocers, butchers, and a real-estate dealer, indicating the better-off Irish working class who moved to western parts of the city (U.S. Census 1872; 1883; Burchell 1980: 47,49; Cherney and Issel 1981: 29).

Most of the employed Irish were laborers or domestics, as we have seen. The Irish accounted for 34 per cent of the servant class in the city in 1880, and only 13 per cent of the total population. Many of them could afford to live only in congested neighborhoods in unsanitary and unhealthful conditions. Family life was either nonexistent or disrupted by the burdens of labor and poverty. Children joined gangs of hoodlums. But Irishmen were able to organize themselves politically, in the Democratic Party as well as the Workingmen's Party. They became involved in city government and took jobs as firemen, policemen, and streetcar conductors (Asbury 1933: 150-154; Shumsky 1972: 139-144;

Decker 1978: 317; Burchell 1980: 116-154).

Poverty meant that many Irish-born appeared on the rolls of public institutions and charities. There were numerous mutual aid associations set up by the Irish, but they relied heavily on public institutions as well. Irish appeared in prisons and hospitals and the almshouse. Statistics show a consistently much higher proportion of Irish than other nationalities in the San Francisco Almshouse between 1869 and 1894. Burchell suggests that this excess is in part accounted for by favoritism on the part of the Almshouse's Irish directors (Burchell 1980).

In her 1895 study of women in the almshouse, Mary Roberts Smith found that among these "erratic creatures" 59.2 per cent were Irish, as were 41.3 per cent of the total almshouse population. Her study indicates what became of Irish women who migrated to San Francisco in the 1870s. She concluded that the Irish women were "less efficient in domestic employments, more liable to drink, and more illiterate than others," and were unstable as a result of both their "Celtic temperament" and female emotionality (Smith 1895: 15). Smith realized that what had happened to many of these women was simply that their husbands had died and they were unprepared for any form of self-support. Of the Irish women in the almshouse in 1895 71.2 per cent were widows. The women averaged 63 years in age; so they were in their thirties and forties in the 1870s. Most had been either married or in domestic service. Eighty-three per cent had been immigrants. Most were admitted as paupers because of intemperance (Smith 1895: 15-25). One Irish domestic suggested to Smith an explanation for the inability of Irish to succeed in the United States which has some cultural resonance:

They're just ready to be paupers when they come over. There isn't any use trying to get ahead in Ireland, for whatever you put on the land only makes the rent more; so there isn't any use saving. And they can't be strong, because they live mostly on potatoes, corn-meal, and sour milk (Smith 1895: 13-14).

Several of the individual stories of these women may be kept in mind as we move on to examine public health in San Francisco and statistics on infectious disease in the next chapter. For example, a 69 year old widow migrated to San Francisco in 1870 and was admitted to the almshouse nineteen years later with rheumatism and neuralgia. Her husband had been English, "a 'good, temperate man'; five children died in infancy of 'water on brain,' two are living 'somewhere'; one son, twenty-six years old, a laborer, could not support her, was recently drowned". Another 71 year old German immigrant was a domestic servant when she came to San Francisco in 1870. She was a "worn-out scrub woman," admitted to the almshouse in 1894 for old age and sore legs. A younger, 51 year old widow who had been a domestic was admitted as an intemperate prostitute. Her data revealed: "Husband recently killed; four children died of diphtheria and measles; untruthful, vulgar" (Smith 1895; Table XVII).

### City Life

Surprisingly, many visitors found San Francisco an unattractive city in the 1870s. William Laird MacGregor, travelling from England, said, "San Francisco cannot be called a pretty or a picturesque town....it presents simply the appearance of a huge agglomeration of bricks and mortar, stone and wood" (MacGregor 1876: 16). Anthony Trollope remarked in 1875 that, "I do not know that in all my travels I ever visited a city less interesting....There is almost nothing to see in San Francisco that

is worth seeing" (Trollope 1951: 541, orig. pub. 1875). Another British visitor commented on the "dense cloud of smoke" that resulted from coal-burning furnaces, producing the "darkeness and dinginess of the city" (W. F. Rae, quoted in Lewis 1962: 169).

Guillermo Prieto, a Mexican political exile, wrote poetically of San Francisco in the 1870s. While undoubtedly subject to inaccuracies, his descriptions are among the most suggestive of what the city was like. His class prejudice was typical of the time, if more dramatically expressed than usual. He said that among the impressive buildings of the main streets:

There are humble structures, always with pointed roofs and always coming singly. These are poor-appearing carriage shops, stables, laundries, or warehouses heaped with tallow and stinking hides. From them issue ragged and ill-kempt monsters whose dripping shirts are an offense to eye and nose. And behind the palaces run filthy alleys, or rather nasty dungheaps without sidewalks or illumination, whose loiterers smell of the gallows....I saw very few beggars. Such as there were carried barrel-organs, fiddles, bunches of flowers, or boxes of matches. Through the richest sections of the city they would pass-- liquory, tattered men and large, down-at-the-heel women in aprons and shawls-- like evil smells in a perfumed garden...Ladies ride in landaus and carriages, leaning back negligently on their furs, white veils floating over their flowered hats. Blue-clad Chinese slink down the sidewalks (Prieto 1938: 8-9, 28).

Prieto was especially struck by the intermixture of different merchants on one street, which he attributed to "the American sentiment of equality".

The ethnic mix of San Francisco was as apparent on the streets of the 1870s as it is today. A contemporary cartoon represents various city "characters" including Chinese of Kearny Street, Irish of Brannan Street, Spanish of Vallejo Street, Blacks of Jackson Street; as well as a gambler, a peddler, some "greenhorns", prostitutes, hoodlums, and a





Chinese leper. William Laird MacGregor commented in 1876 that "In the variety of races which inhabit the city - Americans, English, Germans, Italians, French, Swiss, Spaniards, Chinese - no other American town can compare with it" (MacGregor 1876: 26). He was also impressed by the healthy look of the people. He attributed the "erect carriage and good figures" of the young to "the healthfulness of the sea-breezes which sweep over San Francisco daily, and give tone and vigour to their constitutions, making the generous blood mantle over face and neck" (MacGregor 1876: 27-28). MacGregor speculated on what future generations would be like in such an ethnically mixed city. He concluded that "Living in a healthy climate, with a bracing air, it is reasonable to suppose that California's children may at some future period be the flower of the American people" (MacGregor 1876: 28). The "Flower Children" of 1960s San Francisco were probably not what MacGregor had in mind.

Harriet Lane Levy also recalled the colorful aspect of San Francisco's ethnic mixture. She wrote that the Saturday night promenade on Market Street was a "carnival" of people (Levy 1975: 258, orig. pub. 1937). In spite of his feeling that the foreigners of the city were "full of enterprise, industrious, and intelligent," B. E. Lloyd feared their influence: "The effect on society has perhaps been detrimental. Morality has been at a discount. Social vices have apparently been nourished. The commingling of the different nationalities seems to have bred dissolute habits" (Lloyd 1876: 60).

San Francisco retains to this day the reputation for vice it acquired in the early Gold Rush days. Venereal disease was the most common reason for hospital admission in the 1870s, as we shall see in Chapter Five. But the diseases from which most ethnic immigrants sickened and died were

the dread infectious diseases of childhood, spread in the context of unsanitary living conditions.

The part of the community most famous for vice was that known by the 1860s as the Barbary Coast. It was primarily an area for night life. Prostitution was a major product. The condition of these women was quite pathetic, especially those who were Chinese slaves (Asbury 1933: 108-109, 114-115, 177-182). Guillermo Prieto depicted this district:

Here the vile cauldron brews its concoction from the most disparate elements, harsh gutturals of German, shrill pipings of Chinese, savage grunts of Americans; wailing music, searing drink, women whose glances lash the skin like nettles and whose breasts are livid with alcohol....Blasphemy, murder, abortion and blood were inevitable products of a chaotic and disorganized society ....People of wealth and culture, fine ladies and eminent men of learning, have sometimes fallen into the pit (Prieto 1933: 66).

In a more prosaic way, Frank Roney expressed his disturbance at this aspect of the city in 1875: "vice in every form stalks rampant and seems as irrepressible as a great conflagration [sic] is to a well organized fire department when the supply of water is exhausted" (Roney 1875-76: 2). He compared participation in vice to the abandonment with which people historically faced the great plague. In another apt disease metaphor, B. E. Lloyd described the Barbary Coast:

Like the malaria arising from a stagnant swamp and poisoning the air for miles around, does this stagnant pool of human immorality and crime spread its contaminating vapors over the surrounding blocks.... even the remotest parts of the city do not entirely escape its polluting influence....Licentiousness, debauchery, pollution, loathsome disease, insanity from dissipation, misery, poverty, wealth, profanity, blasphemy and death, are there. And Hell, yawning to receive the putrid mass, is there also (Lloyd 1876: 78-80).

In spite of such tantalizing descriptions, most upper class people,

especially women, were unaware of or chose to ignore the Barbary Coast. It was unusual that Harriet Lane Levy's father permitted her to view part of this area of town (Levy 1975: 269, orig. pub. 1937).

Census statistics from 1880 confirmed that San Francisco had more houses of prostitution and saloons than most cities. Lawrence Larsen reports that "San Francisco had more saloons (8,694) than any other city in the United States except New York (9,067), which was five times larger. A city of comparable size...New Orleans, had 429" (Larsen 1978: 86). But the British traveller, MacGregor, seemed unaware of the unsavory side of San Francisco life. He saw little drunkenness or disturbance, and found churches well-attended. He remarked that vice was confined to proper locations (MacGregor 1876: 41). Few recognized that the vice industry in San Francisco was the only employment many immigrants found available to them.

### Summary Chapter Two

Because San Francisco was newly forming, assimilation of newcomers was relatively fluid. Nativism or ethnic prejudice tended to be focused on the largest non-Caucasian, and most culturally different group, the Chinese. The Irish-born were the largest nationality group in San Francisco and made up 22 per cent of the employed there in 1870. They were usually laborers and domestic servants. They appeared disproportionately in mortality and morbidity statistics and among the unemployed and destitute. The Irish are a good test case of the imputed relationship between immigration, ethnic background, living conditions, and disease. Unemployment and stymied occupational mobility created pessimism and a high suicide rate among all San Franciscans in the 1870s.

Contemporary writings express blatant class and ethnic prejudice, but also some appreciation of the "cosmopolitan" character of the 1870s city. Immigrants were blamed for the havens of vice in the Barbary Coast. Few higher class commentators could identify with the poverty and desperation that propelled people into prostitution, crime and drunkenness. The social utilitarianism of the 19th-century brought a moral judgment upon all human behavior, including the experience of disease.

People at all class levels lived in hotels and lodging and boarding houses. In the immigrant neighborhoods south of Market Street housing and living conditions deteriorated as more people crowded in and neighborhoods became industrial. Social problems developed.

#### Endnotes Chapter Two

<sup>1</sup> There were no apartment houses built in the city until 1884 (Burchell 1980: 39).

<sup>2</sup> Cable cars ran on Clay Street by 1873 and California Street by 1878 (Muscatine 1975: 363; Decker 1978: 213-214).

<sup>3</sup> The relationship, or lack of it, between population density and disease will be discussed in the next chapter.

<sup>4</sup> Only the ethnic groups have changed in expressions of such prejudices today.

<sup>5</sup> John Lawrence has commented that "Most whites believed the Chinese easily tolerated, or even revelled in, the poverty and repulsive conditions into which they were crammed in Chinatown" (Lawrence 1979: 41).

<sup>6</sup> As I write this in the winter of 1982-83, the San Francisco Chronicle daily reports the city's renewed concern for those who live on the streets

and stand in line for charity meals.

<sup>7</sup>There has been much recent research in the historical demography of the American family, including changes in family size and deliberate limitation of births in the 19th-century. See for example, Rose 1942; Coale and Zelnick 1963; Bloomberg et al. 1971; Nag 1973; Polgar 1973; Seward 1973; Wells 1975; Kobrin 1976; Osterud and Fulton 1976.

<sup>8</sup>Anti-Catholic sentiment towards the Spanish was already expressed before California became an American holding. Anti-Catholic feeling was strong against Irish immigrants from Australia and the eastern U. S. among members of the Vigilance Committees of 1851 and 1856 in San Francisco, and within the Know-Nothing Party. Such feelings may have revived in 1877 within the Committee of Safety against the largely Irish Workingmen's Party (Starr 1973: 16, 93-95).

## CHAPTER THREE: IMMIGRATION, DISEASE, AND PUBLIC HEALTH

Anthropologists studying migration recognize that sociocultural change often leads to increased disease incidence. This relationship has been observed cross-culturally and historically. Infectious diseases in particular have accompanied migration and industrialization historically, and accompany them today. Virulence of infectious disease is dependent on density of susceptible people and the number of sources of infection. If a disease is introduced by immigrants to a population rarely or never exposed to that infectious organism, an epidemic will occur, especially in densely populated cities. Conversely, newcomers may suffer far more symptomatic cases of diseases that are common inapparent infections in the native population (Hughes 1966: 143-145; Burnet and White 1975: 128-136; Crosby 1972; McNeill 1977).<sup>1</sup>

The urban tenements in which 19th-century European immigrants settled in America were breeding places for tuberculosis, diphtheria, smallpox, typhus, cholera, and other diseases, from all of which immigrants suffered more than did native residents. To some extent the physical debilitation of most immigrants on arrival may have produced special vulnerability to infections. Immigrants' life-spans were actually no shorter in the United States than if they had stayed in Europe; but they were shorter than those of long-term American residents.

Infectious diseases were prevalent in European countries of origin, but they became virulent on crowded immigrant ships, as they did on the ships and wagon-trains making the journey to California. cursory efforts were made to maintain sanitary conditions on shipboard and to disinfect ships at disembarkation, but they were usually ineffective. There was a great deal of anti-quarantine agitation in the 19th-century because

quarantines interfered with commerce. Holding immigrants in quarantine could have gruesome effects, as thousands died waiting in ships for accomodation in the beds and tents of quarantine hospitals (Read 1944: 265-266; Ackerknecht 1948; Hansen 1961: 44-51, 256; Duffy 1971b: 800-802).

Physicians first became really aware of the diseased state of immigrants when they visited tenements of New York City in the 1850s. People lived in appalling conditions in these "fever nests," with open sewage and garbage piled around them. They had little heat, poor ventilation, no furniture or running water. These areas not surprisingly were the major places hit by the cholera epidemics of the 1830s, 40s and 60s. They were also places where typhus was transmitted by lice. The same areas later became centers for tuberculosis. They additionally suffered from the continual endemic diseases we shall discover in San Francisco in Chapter Four: scarlet fever, diphtheria, whooping cough, influenza, and others (Brieger 1966; Rosen 1972; Smith 1973, orig. pub. 1911).

Tenement life, especially for the "trogloodytes" or cellar-dwellers, could not have been more conducive to disease (Ernst 1949: 49). Stephen Smith observed their conditions for the New York Council of Hygiene in 1865:

As you look into these abodes of wretchedness, filth and disease, the inmates manifest the same lethargic habits as animals, burrowing in the ground. They are, indeed, half narcotized by the constant inhalation of the emanations of their own bodies, and by a prolonged absence of light and fresh air. Here we never find sound health, while the constant sickness rate ranges from 75 to 90 per cent (Smith 1973: 88, orig. pub. 1911)

Sanitary inspectors cited such insalubrious conditions throughout the century. Most immigrants were forced to bathe in rivers where sewage was deposited. The absence of water was responsible for the filthy state of

uncovered wooden privies that served far too many people. Stephen Smith (1973) has left us a vivid account of the misery and disease of "tenant-house rot". His description of its psychological effects is not unlike Colin Turnbull's (1972) portrayal of the starving Ik in Africa.

Initially city administrations felt responsible for care of indigent and ill immigrants. But as immigration increased, along with accompanying ills, the newcomers appeared to be contaminating the rest of the population. Statistics demonstrating the greater susceptibility of Irish and others were used to make this case. Periods of epidemics in cities were times of real social chaos. There were no public health systems until later in the century to coordinate a city's reaction, and the number of deaths could be appalling (Abbott 1924: 583, 593-598, 200-206, 665, 669; Ernst 1949: 54-54; Powell 1949; Rosenberg 1962; Duffy 1966; Baker 1968).

Repeated epidemics of cholera and yellow fever occurred, the first transmitted by sewage-contaminated water and food, and the second by mosquitoes. Immigrants always suffered the greatest mortality from these diseases (Smillie 1952; Rosenberg 1962; Duffy 1971a). The cholera epidemic of the 1850s was a vivid memory to San Franciscans in the 1870s, and during that decade the devastation of yellow fever in the South struck fear in the city.

Originally immigrants were popularly believed to be responsible for and susceptible to disease in ways others were not. They were seen as an immoral population, and disease was regarded as punishment by God for the degenerate life of the poor. The Chinese in particular were associated in San Francisco with dirt, disease, and "wanton lewdness" (Miller 1969). Agitation for public health reform did not begin in earnest until other



classes were seriously affected by epidemics. Until then most aid for immigrants came through their own aid networks and organizations, and through charities and private benevolent groups.

### The Nineteenth-Century Public Health Movement

The most significant health advance of the 19th-century was the sanitary reform or public health movement. The reformers were scientists, physicians, epidemiologists and public officials. The movement began in Europe and England as awareness grew that ill health, especially infectious disease, was seriously disabling the working population. The public health movement had only gradual effect in the United States. Both local and national governments intervened in public health only very late in the century, and there was much political resistance to their doing so. Some physicians, such as those who attended the National Quarantine and Sanitary Conventions in the 1860s (1977) were active in the movement (Kramer 1947; Rosen 1958; Shryock 1960: 163-165).

San Francisco, as a relatively new city, was not much affected by the European public health movement. Even in the cities of the eastern United States there was little awareness of the great public health documents published in England and Europe, the works of Edwin Chadwick, Friedrich Engels, John Snow, William Budd, and Peter Panum in the 1840s and 1850s.<sup>2</sup> Occasionally the 1870s San Francisco medical press mentioned the contemporary work of Rudolf Virchow in Berlin and Max von Pettenkofer in Munich. Like their predecessors, these advocates of social medicine recognized the financial and social costs of the living conditions of the urban working class. They turned attention to preventive measures such as sewage removal, alleviation of overcrowding, better ventilation of buildings,

land drainage and improved water supply. Whether the focus was on financial or humanitarian concerns, and whether the blame was placed on mismanagement or Capitalism, the outcome of action on these matters improved public health. John Snow and William Budd were able to demonstrate the specific transmission of cholera and typhoid fever in the water supply.

Several public health reports, more modest in scope, were published in the eastern United States during the first half of the 19th-century. The reports of John H. Griscom on New York in 1845, Lemuel Shattuck on Massachusetts in 1850, and The New York Citizen's Association Council of Hygiene and Public Health in 1865 had no apparent effect on medical thinking in San Francisco. We shall see in the next chapter that San Francisco physicians, while not sharing the public health consciousness of these unusual men, struggled to demonstrate low mortality figures for their community, compared to other cities.

Prior to the American Civil War, four National Quarantine and Sanitary Conventions were held in major cities of the eastern United States with physicians and members of boards of health and trade attending. As subscribers to the belief that most diseases were not contagious, the participants saw no value in quarantines. The conventions moved beyond this concern and dealt with issues of civic cleanliness, use of disinfectants, registration of vital statistics and the etiology of epidemic and endemic diseases (National Quarantine and Sanitary Conventions 1977). The ideas expressed on these occasions were identical to those expressed among San Francisco physicians a few years later (see Part Two).

Before proceeding to a discussion of public health in San Francisco, it is important to recognize several things. The sanitary movement, use

of vital statistics, and development of epidemiological methods together played a far more significant role in the "conquest" of infectious diseases than did specific medical approaches. But we know this reality only with hindsight. There were few such efforts in the United States during the period in which they occurred in England and Europe. As we shall see, in San Francisco as late as the 1880s there was very little understanding of such ideas. The medical profession remained conservative in their reliance on therapeutic approaches. Among a few of the alternative health practices however, the importance of sanitation and personal hygiene received emphasis. San Francisco experienced the ill effects of industrialization much later in the century than did the cities of Europe and the eastern United States. Ideas from these places floated into San Francisco haphazardly, much as did the infectious diseases brought by immigrants from such urban centers. A period of great bewilderment occurred in San Francisco in the 1870s, as the impact of changing social and disease realities confronted an inadequately prepared medical community.

Several writers have argued that improvement in public health did not occur in the United States until the 1880s. Using life expectancy at birth as a major indicator, Edward Meeker (1972) concludes that it did not improve until late in the 19th-century when fewer children were killed by infectious diseases. He argues too that death rates decreased and disease-specific death rates changed significantly only after 1880. The infectious diseases were those primarily affected. Meeker, like McKeown and others, believes medical practice had little to do with this change. Other important features may have been genetic changes in the disease organisms themselves, improvements in public health efforts, and

improvements in level of living such as better diet and housing and installation of sewers and clean water supplies. From what we know today about susceptibility to and transmission of the major diseases of the 19th-century, the public health argument makes sense. Certainly there was little change in this regard in San Francisco until well after the decade of the 1870s.

Alan Marcus (1979) identifies a further explanation for the slowness of change in health statistics in the 19th-century. Because of the belief that disease was not contagious (see Part Two) local and state boards of health regarded disease as a community problem. It was not until there was more acceptance of germ theory that the significance of the wider society was implicated. After the 1880s attention was given to milk supplies, contaminated by unsanitary processing and transportation. Disease prevention began to be seen as a national problem by the 20th-century. San Francisco in the 1870s however, reflected the limited and localized concerns of that period.

#### "Masses of Putrid Matter": San Francisco Public Health

The infectious diseases from which San Francisco suffered most dramatically, as we shall see in the next chapter, were smallpox, diphtheria, typhoid, scarlet fever, measles, and influenza. Tuberculosis and malaria figured continually in high mortality and morbidity statistics. Henry Harris (1932) has summarized public health conditions in the city. Epidemics brought a flurry of activity; but in spite of the efforts of some reformers the sanitary movement in California did not really get underway until after the acceptance of the bacterial causes of disease in the late 1880s.

Public health and sanitation never gained sufficient attention

during the 1870s for effective action. But lone voices were heard on the subject throughout the period.<sup>3</sup> As early as 1868 the following editorial appeared in the medical press:

In many places throughout the southern portion of the city there are houses under which water lies the year round. This becomes decomposed during the summer weather, and malarial diseases of great intensity, insidious pneumonia and rheumatic fever spring up in consequence. These nuisances can be readily abated by physicians notifying the Health Officer of their existence, and we trust our advice on this subject will not be disregarded by the profession (California Medical Gazette 1868: 1: 16-17).

That year another editorial in this journal advised the use of carbolic acid as a preventive against the prevailing smallpox epidemic (California Medical Gazette Nov. 1868: 111). If actually carried out, this effort might have had some effect on the smallpox virus, which spreads on bedding and other objects in contact with the patient. Carbolic acid is a powerful, but caustic antiseptic.

Only the next year, Dr. Arthur B. Stout was writing on the subject that would dominate San Francisco public health writings through the decade: sewage. His article detailed the construction of the city's sewers and their deplorable state. He called the attention of appropriate public officials to this "atrocious long-continued neglect". He argued that water was the only "radical disinfectant" to be used to flush away dangerous substances. But he discussed other disinfectants and called generally for a preventive and hygienic approach (Stout 1869).

In 1870 the Board of Supervisors began to present discussion of the subject of sewers in their fiscal year municipal reports. The Health Officer was aware that the wards with highest disease statistics in the city "are miserably provided with sewerage":

The Second Ward has no sewerage, and is densely populated with a large proportion of the poorer classes, many of whom suffer for the ordinary comforts of life, and that is a fruitful source of Typhoid Fever. The First, Ninth and Tenth Wards are very poorly drained. Their territory is so level and the grade of the streets so slight as to make it impossible for the sewers to clear themselves, and they become mere reservoirs to receive and retain all the filth of the city. This filth is taken out, at various holes made for the purpose along the streets, by means of scoops and buckets, deposited on the ground in a pile in the open air, where it is suffered to remain until its effluvia has poisoned the air and effected all the injury to health of which it is capable, and then is carted off and dumped into the Bay (S.F. Municipal Reports....1870-71: 296).

The Health Officer, Dr. C. M. Bates, attributed cholera and typhoid and typhus to this source, probably accurately in the case of the first two. He complained that the municipal ordinance requiring privies, cesspools, sinks and drains to be connected to street sewers allowed all the drainage from elevated parts of the city to reach and accumulate in the flatland. This action accounted for the high levels of sickness in such wards: "And thus one portion of our people is allowed to visit pestilence upon another portion" (San Francisco Municipal Reports....1870-71: 310). As we shall see in Part Two, fear of contaminating sewage arose from the miasmatic theory of disease etiology, not from an understanding of bacteriology.

A number of San Francisco doctors supported this point of view in their writings. Citing Stout's article specifically, Dr. J. Campbell Shorb called upon improvement of the city's sewage system to combat malarial "Town Fever" (Shorb 1872: 331). An editorial in the Pacific Medical and Surgical Journal argued in 1874 that sewers themselves were the problem. The city of Philadelphia remained healthy, it said, because open cesspools and not unventilated sewers, were used there (PMSJ 1874 XVI(3): 137-138). A Montgomery Street physician commented in 1867

on the danger of poor drainage in San Francisco:

What a disgusting condition are we not reduced to in this city! Privies overflowing, the contents percolating into the surrounding porous, or flowing under the dwelling houses; masses of putrid matter, in all stages of decomposition, allowed to accumulate; a flood comes and carries it into cellars, crevices, etc.; the sun bursts forth and dries it up, and then we know not the hour when this magazine of fever will open upon us and cut us down like the sword of a devastating and relentless enemy (Hall 1867: 78-79).

The next several Health Officers of San Francisco continued the campaign for improved sanitation in the city. Henry Gibbons, Jr. wrote of it in 1875 and J. L. Meares in 1876 (San Francisco Municipal Reports ....1874-75; 1875-76). The latter commented that most of the city sewers were defective in size, material, grade, outlet and ventilation, or all of these features at once: "they and the equally defective house drains form an irrigating system which has already made a disease-breeding swamp of a considerable portion of the city" (San Francisco Municipal Reports....1876-77: 391). Meares began a battle specifically against the Chinese quarter of the city which I shall discuss in more detail later. He wanted the city to pass sanitary laws by which houses could be declared unfit for habitation, especially because of poor drainage. In his opinion it resulted in diphtheria, typhoid fever, smallpox and other diseases.

The Health Officer was supported in part by the San Francisco newspaper press. From 1870 on articles appear in the newspapers calling for cleaning of the "filthy streets" (e.g., see Daily Alta California Feb. 1870; San Francisco Chronicle Jan. 12, 1877: p. 1, c. 1). The "filth" in streets was not the litter we know today. Streets of 19th-century cities became rivulets when it rained carrying discharges from slaughter-

houses, stables, overflowing garbage and leaking sewage. Simply the presence of thousands of horses produced a problem totally unfamiliar to us today. Horse manure attracted enormous numbers of houseflies. Health officials in Rochester, New York once estimated that horses of the city in one year produced enough manure to cover an acre 175 feet high, breeding sixteen million flies. The role of flies as disease vectors was not understood in the 1870s, but most people believed in the miasmatic theory. According to this viewpoint, rotting organic and vegetable matter in the streets was responsible for disease. During the summer dry season in San Francisco the city's winds must have blown dry horse manure and other refuse over people's faces, clothes and merchandise, and in open windows (Tarr 1971; Leavitt 1982: 70-71). Unlike other western cities, San Francisco did have mechanical sweeping machines by 1880, probably as a result of this newspaper agitation. They cleaned busy streets once a week, being only partly effective (Larsen 1978: 62).

While J. P. Meares was Health Officer the San Francisco Chronicle joined his sanitation campaign, but criticised his methods. For example, in January 1877 an editorial complained that he and his inspectors told people who had "bad smelling yards" from defective sewers that smallpox did not arise from this cause. Consequently people did not clean up and smallpox continued (San Francisco Chronicle Jan. 4, 1877). Undoubtedly, the disease would have continued in any event since it is not spread in contaminated water. The newspaper further commented that month: "The city was never in a dirtier or worse sanitary condition than now. There are pestilential pools and spots all over it, and by no means the worst of them in the Chinese quarter. At North Beach there is a literal lake of filth whose exhalations are rank with the most malignant diseases"



(San Francisco Chronicle Jan. 29, 1877: 2). The paper attributed the city's high death rate, and the prevalence of diphtheria and smallpox, to these conditions.

The public was naturally influenced by newspaper revelations about the San Francisco sewer system. A British visitor who described life in the good hotels of the city commented that each room was equipped with a marble washstand with hot and cold water. This arrangement saved servants having to carry water, but it meant "direct communication with the sewers and drains. It is however common to all Hotels in the United States, and the fruitful cause of much Typhoid fever and Diptheria" (MacGregor 1877: 40).<sup>4</sup>

Some disputed this point of view. For example, in the medical press that same year it was claimed that diphtheria did not arise from drains, sewers and water closets: "In the city of San Francisco many of its most fatal visitations were in the cleanliest dwellings, where hygienic laws were strictly enforced....it was often most active and fatal in towns and rural districts which enjoyed every apparent hygienic advantage" (PMSJ 1877 Aug. No. 3: 117-118). Again, the city was facing a disease communicated by personal contact. But the Health Officer continued his crusade to improve the condition of sewers in his municipal reports for the rest of the decade.

Most of the city's public health reformers were physicians. By the end of the 1870s the medical profession adopted sanitary matters as part of its sphere of responsibility. For example, the major medical journal of the city commented in 1878 that the public health movement would not personally benefit physicians in that it would "cut off their own supplies by sapping the fountains of disease". Nonetheless physicians

worked "untiringly trying to teach laws of health to the multitude and establish protective legislation" (PMSJ 1878 XXI(1): 26-27). As we shall see in later chapters, this was a somewhat vainglorious assertion. But the journal continued to encourage members of the profession to support hygienic measures. They were reminded that "Sooner or later death must come, and this will always give business to the doctor". Besides, reduction in childhood mortality would increase their numbers of patients, and these people would be "feebly constituted, or inheriting some physical vice, and...be subjects of medical supervision all their lives". Physicians "would prosper on the health of the community" even if sanitary measures saved lives (PMSJ 1878 XXI(1): 35-36). It is hard to tell if this was a cynical argument or an expression of honest anxiety about the future role of medicine in competition with public health efforts.

Wise physicians began to associate and embrace within their professional purview three aspects of community health. They argued that the physician must also be a hygienist and sanitation educator; otherwise his clients would turn to alternative practitioners, or "quacks" (Chipman 1878). It was the physician's duty to educate the public against such alternatives. By the end of the 1870s preventive sanitary measures were urged in opposition to quarantines, which created too much commercial hardship (PMSJ 1879 XXII(6): 287; 1880 XXII(9): 428). As germ theory became accepted, the relevance of antiseptics was proven (Wythe 1879: 1-10).

### Summary Chapter Three

Migration is associated with ill health cross-culturally. Infectious diseases especially are spread by people on the move. The urban settlements of 19th-century European immigrants in the United States were breeding grounds for these diseases. As early as the 1850s physicians began

to report the appalling state of health among immigrants in New York and other eastern cities. Until later in the century no public mechanisms existed to coordinate public health actions. Chaos occurred during epidemics. Immigrants were often blamed for creating and spreading disease. It was argued that they were being punished by God for immoral behavior. Because of the lack of public aid, immigrants had to rely heavily on their own mutual aid associations and charities.

In Great Britain and Europe the public level of concern over sanitary reform was highly developed by the 1870s. But interest in health as a public matter was much slower in coming to the United States. Physicians in San Francisco were familiar with the European social medicine movement, but their suggestions for sanitary reform were stymied by official indifference and inaction. Overall, there was little understanding in the 1870s, even among physicians, of the use of vital statistics and epidemiological methods. Inaccurate beliefs about the etiology of infectious disease ironically propelled the sanitary reforms which actually did prevent these diseases. But reforms were slower in San Francisco than in cities of the eastern U. S. Certainly disease prevention was regarded as only a local community concern, even when epidemics swept the whole nation.

In San Francisco those concerned with public health, chiefly the Health Officer, focused on the state of the sewer system in the 1870s. Sewage drained through street sewers from individual cesspools, privies, and drains. The city's hilly terrain caused sewage from the heights to flow to the flatlands, creating a contamination of poorer by richer neighborhoods. The condition of San Francisco's sewers undoubtedly did increase incidence of typhoid and cholera. But smallpox, diphtheria, scarlet fever, measles, whooping cough, and other diseases spread because

of other living conditions.

#### Endnotes Chapter Three

<sup>1</sup>Old World diseases had a genocidal effect on native American Indian populations when the Spanish, English, French and others first arrived in the New World. These first immigrant-borne diseases had devastating impact on the non-immune Indians. Populations in some places, like the West Indies and California, were almost completely eliminated (Taylor and Hoaglin 1962; Cook 1972; Crosby 1972, 1976; Boyd 1975; Dobyns 1976; McNeill 1977).

<sup>2</sup>For analysis of these works see Budd 1849, 1931; Panum 1940; Winslow 1943; Engels 1958; Rosen 1958; Brown 1961; Chadwick 1965; Flinn 1965; Snow 1965; Lilienfeld and Lilienfeld 1977; Lilienfeld 1978; Pelling 1978; Ringen 1979.

<sup>3</sup>There had been a Health Officer appointed since the Gold Rush period. The first, John Williamson Palmer, found it impossible as City Physician to treat the innumerable needy sick. He gave up the practice of medicine (Muscatine 1975: 241).

<sup>4</sup>Susan Strasser (1982: 85-103) provides a discussion of the advent of indoor plumbing in the United States.

## CHAPTER FOUR: "ALL THAT MAN HOLDS DEAR":

## THE VITAL STATISTICS OF INFECTIOUS DISEASE

"Died from Natural Causes": The Collection of Vital Statistics

The California State Board of Health was established in 1870 and Dr. Thomas M. Logan<sup>1</sup> became its Permanent Secretary. He also assumed the office of Registrar of Births, Marriages and Deaths. He recommended to the legislature that they pass a new act requiring registration of vital statistics by local boards of health. Logan began the difficult process of sending circulars, blank forms and schedules to County Clerks, Recorders, officers of charitable organizations, hospitals, prisons, and private physicians to collect mortality statistics (State Board of Health, First Biennial Report...1870 and 1871: 3, 19, 22, 49, 54). Faced with the overwhelming difficulties of collecting reliable statistics, Logan attempted to explain some of the pitfalls. But he also argued forcefully for the value of vital statistics:

Faithfully collected and skilfully managed, these statistics furnish accurate knowledge of the most important facts of each citizen, and also the data upon which governments and communities, as well as individuals, may base their action...the prevalency and fatality of every disease, and likewise the ratio of deaths by a special disease to the total number of cases of the same disease; that is, the chance of recovery, when attacked by this disease, are revealed. Life, health, property--all that man holds dear, are thus, we see, involved in these statistics (State Board of Health, First Biennial Report...1870 and 1871: 54).

Logan looked forward to the establishment of a system of state medicine or public health in California based on the collection of accurate statistics. He must have felt continually frustrated in this aim.

In 1873 Logan recommended fines and penalties to force compliance

with the law requiring collection of vital statistics. He again cautioned about the unreliability of his statistics:

Unfortunately, owing to the difficulties which attend a correct diagnosis, such as the less definite employment of nosological nomenclature, which allows many deaths to be credited to the wrong disease, and the shameful fact that the most ignorant non-professional persons are permitted to give a certificate of death, but little reliance can be placed on such statistics as to special diseases (State Board of Health, Second Biennial Report...1871, 1872, and 1873: 39).

Taking a new tactic, under the influence of British sanitarians William Farr and John Simon, Logan argued that the health of workers has a decided effect on business. He suggested that three-fifths of San Francisco's population was ill in 1872. Using Farr's arguments, Logan said that it cost California fifty dollars a year to support and educate a child from birth to maturity. The death of a child under age fifteen was a lost investment of the recompense of adult work (State Board of Health, Second Biennial Report...1871, 1872, and 1873: 4, 8-9, 20; see also Rosen 1958; Eyler 1979; Ringen 1979).<sup>2</sup>

Logan complained that the legislature was indifferent to the problem of lack of compliance. He said that returns of vital statistics "have been becoming more and more irregular and imperfect, and are, therefore, utterly worthless for the purposes of statistical compilation and discussion" (State Board of Health, Third Biennial Report...1874 and 1875: 8-9, 20).

The Health Officer of San Francisco, Dr. C. M. Bates,<sup>3</sup> was faced with a similar problem. He said in 1870:

In consequence of the heterogeneous nomenclature of diseases adopted by our cosmopolitan professional brethren, a proper nosological arrangement is almost impossible. This is more particularly the case, when physicians fill out a certificate of the death of a patient and give the cause as being for want of breath,

or died from natural causes (S. F. Municipal Reports... 1869-70: 214).

Deaths attributed to marasmus or atrophia meant the same thing, he argued, "wasting away from a defect of nourishment," a condition most people reach before death.

"The Very Extreme of Necessary Mortality": Overall Mortality Statistics

In the following discussion of overall mortality figures for the city in the 1870s it will become clear how the unreliability of both vital statistics and population figures make any conclusions suggestive at best.

The Health Officer calculated San Francisco's mortality rate each year. It was also reported in the annual reports of the State Board of Health. While Henry Gibbons, Jr. was Health Officer (until 1878) the figures appeared in the Pacific Medical and Surgical Journal.<sup>4</sup> The mortality rate was calculated by dividing the raw mortality, collected as described, by the population at risk. The latter figure was based on either the federal census of population or on figures reported in the annual city directory edited by Henry Langley. Often the Health Officer calculated his own estimate of population somewhere between the two. As we saw in Chapter One, population figures were quite unreliable. Thus, mortality rates were based on unreliable death reports and unreliable population estimates. However, they were relied upon to prove that San Francisco was an unusually healthy city.

Table Four shows the mortality rates between 1866 and 1881 for the city, and the percentages of deaths reported from zymotic and miasmatic (infectious) diseases. Given the problems in accuracy of mortality statistics, it is difficult to reach any real conclusions about them. The mortality rate ranged from a low of 15 between 1878 and 1880 to a high

TABLE FOUR: ANNUAL MORTALITY RATE AND PERCENTAGES OF DEATHS  
FROM ZYMOTIC AND MIASMATIC DISEASES, SAN FRANCISCO 1866-1880

YEAR	RAW MORTALITY	MORTALITY RATE (per 1,000)	ZYMOTIC DISEASES	MIASMATIC DISEASES
1866	2519	21.0	20.2% (510)	
1867	2492	19.2	16.1% (402)	14.3% (357)
1868	3577	25.6	32.4% (1158)	
1869	3491	23.3 (L)	26.5% (926)	25.1% (876)
1870	3351	22.3 (C)	18.6% (622)	16.3% (546)
1871	2957	19.6 (C) 17.1 (L)	13.5% (399)	11.5% (341)
1872	3154	16.9 (L est) 18.5 (C est)	13.5% (425)	12.0% (378)
1872-73	3641	19.3 (L)	17.9% (652)	16.6% (606)
1873	4002	21.6 22.2 (est)	22.7% (908)	
1873-74	4013	20.0 (L)	23.0% (922)	
1874	4044	20.0 (L)	20.9% (845)	
1875	4436	19.0 (L)	17.0% (754)	
1876	5669	20.3 (est)	29.2% (1654)	
1877	5505	18.4 (est)	29.4% (1621)	
1877-78	4450	16.6 (est)	22.9% (1020)	21.7% (966)
1878	4740	15.8 (est)	17.8% (842)	
1878-79	4493	14.8 (L)	18.6% (740)*	17.4% (692)*
1879	4611	15.1 (est)	13.4% (617)	
1879-80	4340	14.8 (L) 18.5 (C)	14.1% (545)*	12.3% (477)*
1880-81	4287	18.3 (C)	16.5% (627)*	14.6% (556)*

Population used: L= Langley directory; C= U.S. Census; est= official estimate

\* Excluding Chinese

Sources: San Francisco Municipal Reports: Health Officer's Report, 1869/70-1873/74; Pacific Medical and Surgical Journal: Mortality Statistics of San Francisco 1870-1877; Second Biennial Report of the State Board of Health of California For the Years 1871, 1872, and 1873.



of 26 in 1868 when there was a smallpox epidemic. Zymotic and miasmatic diseases accounted for about one-quarter to one-third or more of deaths each year. We shall discuss these diseases more specifically later in the chapter.

At the opening of the decade, Thomas Logan introduced the theme of San Francisco's "salubrity". This concept was to be promoted in health statistics for the rest of the 1870s. Given the tentative nature of these figures both in San Francisco and other cities, it is surprising that their reporters insisted on making comparisons. Table Five shows how San Francisco compared to other cities early in the decade. Logan reported in 1871 that San Francisco was second only to St. Louis in good health, with a death rate of 21.4 per thousand. He said enthusiastically, "with good drainage, sewerage and proper attention to ventilation, and the admittance of sunlight into the dwellings of the rich as well as the poor, not only San Francisco, but all the towns of California, will present a lower death rate than any city in the world" (State Board of Health, First Biennial Report...1870 and 1871: 57-58). Logan elucidated what was meant by a low death rate:

it is well established by sanitarians that eleven deaths annually in every one thousand living population are unavoidable, but that any excess over this in healthy countries is preventable....cities are more unhealthy, but even for these, seventeen per one thousand is deemed the very extreme of necessary mortality....as a general average for all cities, twenty-five per one thousand... is practically regarded at the present day as a fair standard of health; whilst under twenty is deemed very healthy, and over thirty decidedly unhealthy (State Board of Health, First Biennial Report...1870 and 1871: 59).<sup>5</sup>

The calculation of mortality figures for San Francisco was clearly directed towards the ideal number. For example, Henry Gibbons, Jr. variously stated the figure for 1871 as 19.6 using census population,

TABLE FIVE: SAN FRANCISCO MORTALITY  
 COMPARED TO OTHER CITIES, 1870 and 1872

1870

CITIES	U.S. CENSUS 1870	RAW MORTALITY	MORTALITY RATE (per 1,000)
St. Louis	312,963	6,670	21.3
San Francisco	150,351	3,214	21.4
Sacramento	16,298	391	24.0
Boston	253,984	6,096	24.0
Chicago	299,370	7,342	24.5
Philadelphia	657,179	16,750	25.5
Baltimore	267,599	7,262	27.1
New York	927,436	27,175	29.3
New Orleans	184,688	6,942	37.6

SOURCE: Adapted from State Board of Health of California, First Biennial Report For the Years 1870 and 1871: 58).

1872

CITIES	DEATH RATE	CITIES	DEATH RATE
San Francisco	17	Liverpool	27
St. Louis	20	Leeds	27
Cincinnati	20	Glasgow	28
Baltimore	25	Manchester	28
Philadelphia	26	Dublin	29
Chicago	27	Leghorn	30
Brooklyn	28	Venice	30
Boston	30	Milan	30
New Orleans	30	Vienna	31
Newark	31	Genoa	31
Halifax	31	Stockholm	31
New York	32	Nice	31
Savannah	36	Havre	31
Montreal	37	Rotterdam	31
Memphis	46	Berlin	32
Valparaiso	66	Bolonna (sic)	32
Zurich	13	Naples	35
Geneva	19	Florence	35
Basle	20	Rome	36
London	21	Prague	41
Paris	21	Munich	41
		Cadiz	44

SOURCE: Adapted from State Board of Health of California, Second Biennial Report For the Years 1871, 1872 and 1873: 42 .

17.1 using Langley's figure, and 16.9 using a mean figure from 1871 and 1872. Still later he reported a rate of 17.4. Gibbons obviously aimed in these calculations for "the very extreme of necessary mortality," or a rate of 17 (Gibbons 1872: 386; 1873: 418; 1874: 485). Such variations in the death rate continued through the decade, with Gibbons more and more favoring calculations from the city directory rather than the federal census (which, of course, had been taken in 1870). Logan's rates differed from Gibbons' depending on his choice of population source. The fact that he used fiscal years and Gibbons calendar years only made matters worse.

Comparisons to other cities demonstrated San Francisco's excellent reputation for health. In 1873 Thomas Logan reported a death rate for the city of 17 based on a Langley population estimate, that compared favorably to rates of 42 American and European cities (Table Five). Only Zurich had a lower rate (13), and most of the cities demonstrated death rates in the 20's and 30's. San Francisco was the healthiest city. That these figures were undoubtedly extremely unreliable for most cities and that comparability was probably very poor did not besmirch the city's reputation. Nonetheless, Logan remained vigilant in the cause of public health, and would not let San Francisco rest on her laurels: "Let us not trust too much to our healthful Summer breezes, but with clean streets and well drained houses, let us continue to maintain our position as the healthiest city" (State Board of Health, Second Biennial Report...1871, 1872, and 1873: 43).

#### "Were It Not For The Chinese"

By 1875 the high rate of disease among the Chinese residents of San Francisco worried Henry Gibbons, Jr. The statistics for this

"alien" population were damaging the reputation of the city as a whole. He began to estimate separate rates for the Chinese and white populations, as did Thomas Logan (Gibbons 1875: 437; State Board of Health, Third Biennial Report...1874 and 1875: 37). Gibbons commented on the 1875 death rate of 19: "As is always the case...were it not for the Chinese, our death rate would be still further reduced, amounting to eighteen and a half per thousand in 1875, the Chinese rate being over twenty-seven per thousand" (Gibbons 1876: 393). San Francisco health officials used the Chinese as scapegoats for most epidemics and ill health during the 1870s. As we shall see in Chapter Five, anti-Chinese sentiment was strongly expressed by Dr. J. L. Meares, the Health Officer who succeeded Gibbons in 1876 (Trauner 1978: 73).<sup>6</sup>

Dr. Meares' reports to the Board of Supervisors after 1878-79 provided separate tables of Chinese statistics. In 1880-81 Meares accepted the new federal census figure for calculation of an overall mortality rate of 18.27 from the previous low of 14.8. But he argued that without the Chinese the figure would be 17.20 (again, the acceptable 17). He commented: "So long as these aliens are permitted to live in this overcrowded condition (in the very heart of the city), with their filthy habits and customs....coming in daily contact with our citizens, as servants, laundrymen, and as ordinary laborers....they are a constant source of danger" (S. F. Municipal Reports....1880-81: 253-254). The death rate, inflated by inescapable new census calculations, was imputed nevertheless to the Chinese presence (see Chapter Five).

Thus the new, lower 1880 federal census figures on San Francisco's population threw all mortality calculations of the previous decade into severe question. Dr. Meares said regretfully, "If the census taken by

the U.S. Government is correct then our population has undoubtedly been over estimated for several years. This over estimating the population of cities, whether intentionally or unintentionally, causes much embarrassment and lessens very much the value of vital and mortuary statistics" (S. F. Municipal Reports 1879-80: 413). Meares as much as admitted that population figures were deliberately exaggerated to present a favorable death rate.

The new Permanent Secretary of the State Board of Health, Dr. F. W. Hatch, stated definitively that the federal census showed previous estimates of total population to be in error.<sup>7</sup> Hatch said that he adopted the census enumeration, but he was sure that it was inaccurate. When the enumeration was taken many people were at "watering places" or mountain "sanitary resorts" and were not counted (State Board of Health, Sixth Annual Report....1880: 6). Thus the federal census missed not only the "disreputable" people mentioned by Henry Langley in 1871 (see Chapter One) but the well-to-do who escaped the city during the summer months.

These physicians must not be blamed for the unreliability of their mortality figures. In their efforts to document the health of the city and state they recognized the unsteady nature of the population and the uncertainty of death certificate data. But they desired to put the best light on the matter for as long as possible. There were good arguments for their assumption of a higher city population than that reported by the federal census. The latter was notoriously incomplete, and local estimators were more aware of the city's population fluctuations. The fact that a healthy mortality rate had been semi-officially set at 17 per thousand was a powerful influence. It was important for

these representatives of San Francisco's medical community to prove that it was the healthiest of cities. There is no way to judge today whether it was or not. Certainly this relatively new community was not as unhealthy as some of the old, densely-populated cities of Europe and the eastern United States. In none of these places however, could people effectively deal with the chief cause of high death rates, the infectious diseases.

#### Zymotic and Miasmatic Disease Prevalence

Examination of the specific causes of deaths in San Francisco demonstrates that certain infectious diseases were blamed for failures in the city's reputation as much as were the Chinese and faulty sewage disposal. The State Board of Health and the City Health Officer both kept records on specific diseases, according to systems of nosology they felt to be useful. They calculated limited statistical comparisons from them. Their efforts were hampered again by the very poor reliability of the reports on which their figures were based. For example, infant mortality rates could not be calculated at all because there were no statistics on numbers of births (S. F. Municipal Reports....1880-81: 251). Collection of birth statistics had to wait for the 20th-century (Cassedy 1965: 223). Cause-specific and age-specific death rates were not calculated by these men. They did collect the raw data; but given the changing population figures used, I think it is wiser to follow their own model and rely on simple percentages of total deaths.

Henry Gibbons, Jr. devised a nosology of disease in which the class of Zymotic Diseases included most of those we call infectious or communicable today. It contained three orders:

1. Miasmatic Diseases: typhoid fever, typhus fever, scarlet fever, diarrhea, dysentery, erysipelas, smallpox, diphtheria, croup, whooping cough, measles, pyemia (toxemia), and "others".

2. Enthetic Diseases: primarily syphilis

3. Dietic Diseases: primarily alcoholism

Gibbons also created four other classes of disease:

A. Constitutional Diseases: including cancer and consumption (tuberculosis)

B. Local Diseases: apoplexy, epilepsy, and brain and organ diseases

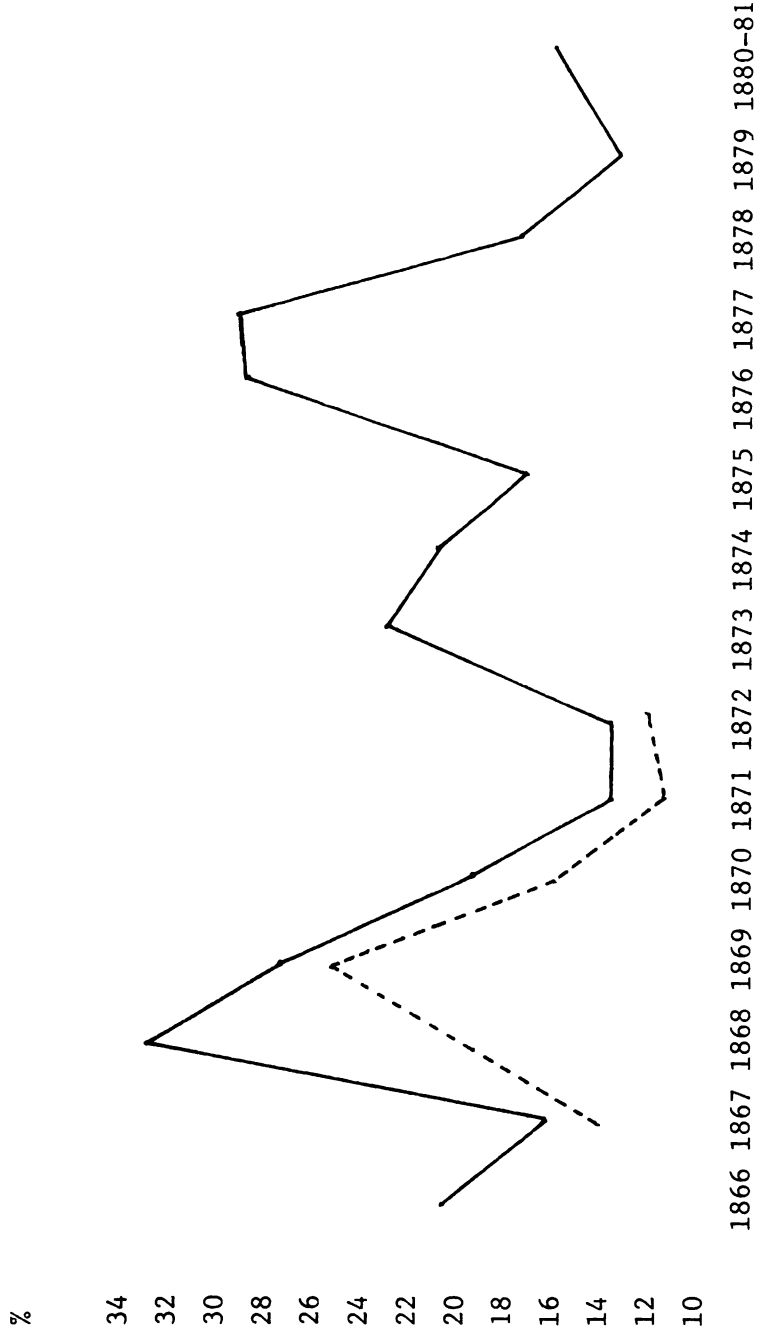
C. Developmental Diseases: including premature birth, puerperal fever, old age, and nutritional diseases

D. Violent Deaths. (see tables in PMSJ reports)

Given the inaccuracies in diagnoses of diseases, the confusion in nosology, and overlapping of symptoms, we must view this effort to quantify disease experience with more than a grain of salt (see Richmond 1954b; Rosen 1958; Pelling 1978). But it was probably the best that could be done. The way in which diseases were perceived at the time is of greater importance than the accuracy with which they were diagnosed because we are examining the cultural construction of disease (see Chapter Six and Sontag 1978).

Graph One illustrates the epidemic nature of infectious diseases in San Francisco during the 1870s. It shows high levels of mortality from zymotic diseases during the smallpox epidemic of 1868, the scarlet fever epidemic of 1873-74, and the combination of diphtheria and smallpox epidemics of 1876-77. The class of Local Diseases (chiefly heart and organ failures) accounted for greater mortality each year. But zymotic diseases killed between 13 and 32 per cent of the San Franciscans

GRAPH ONE: PERCENTAGE OF TOTAL MORTALITY ACCOUNTED FOR BY ZYMOTIC AND MIASMATIC DISEASES, SAN FRANCISCO 1867-1880



Zymotic = —————

Miasmatic = - - - - -

1880-81 excludes Chinese

Sources: As for Table Four



who died each year from 1866 to 1881 (see Table Four). The exclusion of tuberculosis (consumption, phthisis) from the zymotic disease class is significant because it was a major cause of death in the city. It was regarded as a constitutional disease which did not have the characteristics of those in the zymotic category. Tuberculosis alone killed between 11 and 17 per cent of those who died each year.

Again, efforts were made to show that these rates compared favorably to other cities (Table Six). For example, 22.6 per cent of San Francisco's deaths in 1873 were attributed to zymotic diseases, compared to 37.8 per cent in Chicago, 32.3 per cent in New Orleans, 31.0 per cent in Boston, 26.6 per cent in Birmingham, England, and only 18.8 per cent in Philadelphia. San Francisco's constitutional disease rates, including tuberculosis, tended to be higher than those in other cities. Henry Gibbons, Jr. commented on such comparisons in 1874 that "at the very outset a serious difficulty to accurate classification presents itself, in the want of correctness and clearness of diagnosis" (S. F. Municipal Reports...1873-74: 359).

Graph Two illustrates the key infectious disease killers for each year between 1869 and 1877. Consumption showed highest percentages of total deaths, except during the diphtheria epidemic of 1877. Henry Gibbons, Jr. introduced a commentary about consumption in 1870 that became a theme for this and the next decade:

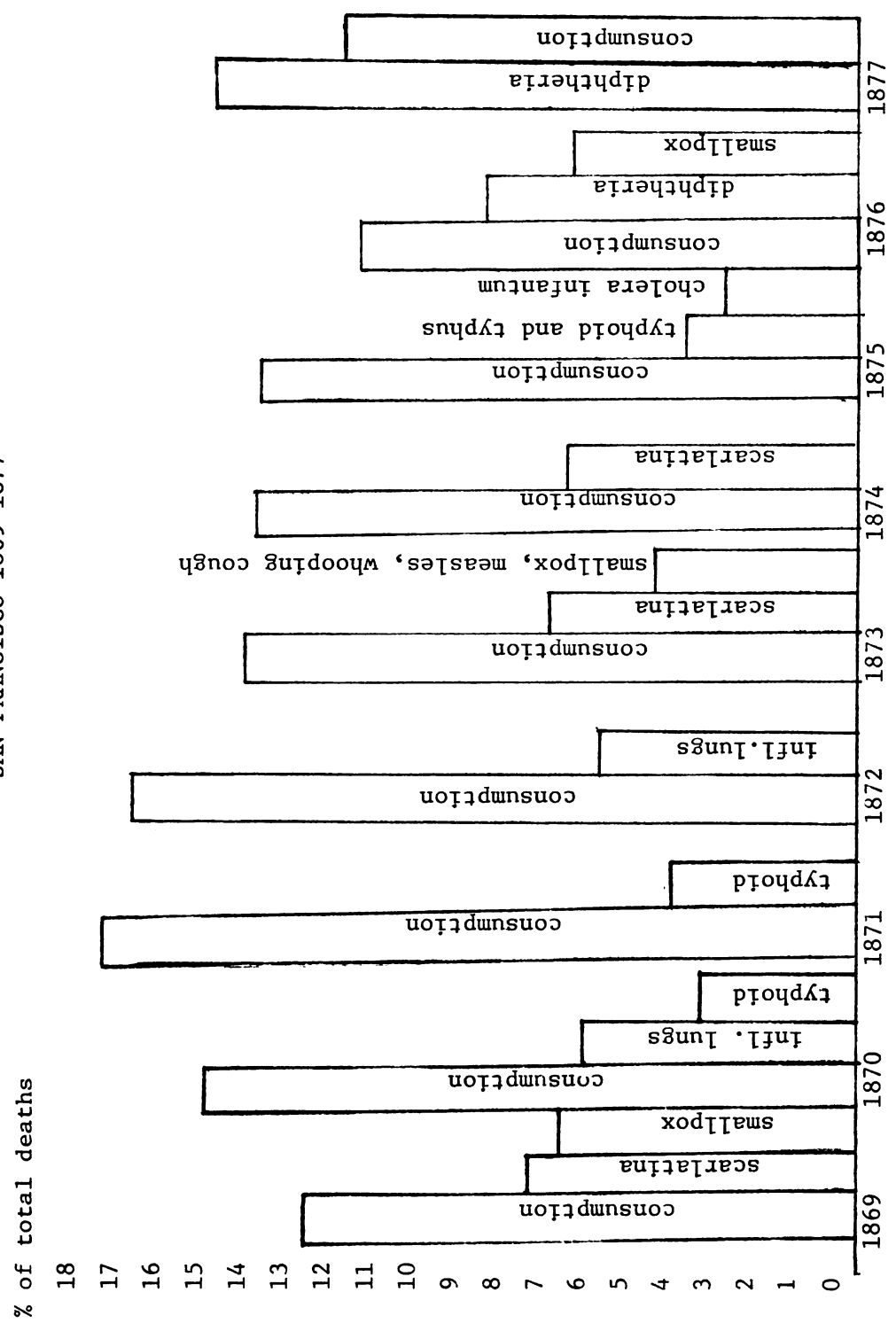
Consumption is a disease whose mortality usually bears a very uniform relation to the population. Yet it appears that the deaths from this cause have markedly increased during the past year....It is unnecessary to repeat what we have often said on this subject, that our hospitals and our city are the rendezvous for the sick, more especially consumptives, of the entire State. In saying this we by no means claim that the immediate climate of San Francisco is

TABLE SIX: MORTALITY BY DISEASE CATEGORIES  
 SAN FRANCISCO COMPARED TO OTHER CITIES, 1872 OR 1873

CITIES	ZYMOTIC DISEASE	CONSTITUTIONAL DISEASE	LOCAL DISEASE	DEVELOPMENTAL DISEASE	VIOLENCE	UNKNOWN
S. F. 1872-73	17.9	18.4	38.8	11.3	4.2	9.4
S. F. 1873	22.6	17.4	36.2	10.7	4.2	8.9
New York 1872	36.2	20.2	33.4	6.2	4.0	---
Philadel- phia, 1873	18.8	18.5	41.6	17.2	3.7	.2
Brooklyn 1873	31.8	17.6	34.9	12.9	2.7	.1
Chicago 1873	37.8	12.8	36.9	8.6	3.9	---
Boston 1873	31.0	20.9	32.1	12.0	3.9	.1
Cincinnati 1873	34.9	14.4	37.3	9.3	3.4	.7
New Orleans 1873	32.3	14.4	38.8	10.6	3.1	.8
Buffalo 1873	29.1	14.3	35.5	10.3	3.6	5.2
Liverpool 1872	24.9	16.7	38.9	12.9	4.3	2.3
Birmingham 1873	26.6	13.5	38.3	16.6	4.9	.1
New Castle 1873	25.8	14.3	40.3	14.3	4.1	1.0

SOURCE: Adapted from San Francisco Municipal Reports...1872-73: 333;  
 1873-74: 361. Means of calculation of the rates was not explained.

GRAPH TWO: PERCENTAGES OF DEATHS BY KEY DISEASES  
SAN FRANCISCO 1869-1877



SOURCE: Pacific Medical and Surgical Journal Mortality Reports

not insalubrious for persons with lung diseases, but we desire simply to indicate our firm belief that our climate is not chargeable for all that figures alone may show in this particular (Gibbons 1871: 400-401).

The presence of "consumptives", like that of Chinese, was apparently seen as an abnormal part of the city; i.e., statistics of the ill health of these two populations were regarded as aberrations. Without them, the city would certainly be the healthiest in the world. The later promotion of a state hospital for consumptives located elsewhere was as much an effort to rid the city of tuberculosis sufferers as was the "Chinese Must Go" slogan of the Workingmen's Party to rid it of Chinese.

The other key infectious causes of death illustrated in Graph Two included epidemics of scarlet fever (scarlatina), smallpox, typhoid fever, measles and whooping cough, cholera infantum and diphtheria. Inflammation of the lungs was also a big killer, probably related to tuberculosis. These diseases accounted for between three and fourteen per cent of deaths each year. The theme of San Francisco's salubrity appeared in discussion of deaths by specific diseases as well. As the Health Officer observed the ups and downs in specific disease rates, he attempted to provide explanations, whether it was because of the poor sewer system, changes in the weather, the presence of the Chinese, or of the tubercular.

Henry Gibbons, Jr. was clearly concerned with presenting San Francisco as a healthy city. To this end, he pointedly stressed the epidemic nature of such diseases as measles, scarlet fever, smallpox, whooping cough, etc. Otherwise, he viewed each year as extraordinarily healthy. For example, about 1874 he comments, "But for the prevalence of scarlatina in epidemic form, which is now happily rapidly disappearing, the smallness of the mortality must have been remarkable" (Gibbons 1875: 437). He reiterated this argument for 1875, saying that he

doubted if any large city in the world had as good a mortality record as San Francisco. Only scarlatina had been epidemic there over the past five years, while many cities had had other epidemics (Gibbons 1876: 393).

In his own mind, Gibbons apparently kept deaths from infectious diseases separate from the total. Perhaps he regarded them as aberrant because most of these deaths were suffered by the foreign-born and by children. He noted that nearly a quarter of the smallpox deaths in 1876 were among children under age five, who had probably not been vaccinated (Gibbons 1877: 401).

When J. L. Meares replaced Gibbons as Health Officer there was a return to a much greater orientation to public health and sanitary solutions. He reported "a sad record of deaths from diseases which for the most part are preventable". Meares typically argued about the diphtheria epidemic of 1876-77: "it is a matter of no importance whether this disease is generated by filth or whether the germs arising from some unknown cause are propagated and fed by it. All authorities agree as to the depressing influence of bad drainage, foul sewers and other accumulations of decaying animal and vegetable matter" (S. F. Municipal Reports... 1876-77: 393-394). Meares advocated the principal explanation of diseases of his time, the miasmatic theory (see Chapter Six). He also blamed the Chinese population for disease prevalence, as we have seen. But his own statistics show that the Chinese did not contribute heavily to the city's death rate from infectious diseases. Statistics on this population were so poor that the vast majority of their deaths each year were assigned "unascertained causes". As much as eighty per cent of their deaths in some years were without known cause. It could not be demonstrated that the Chinese contributed great numbers to deaths from zymotic diseases.

That they tended to be settled as single men without families may mean that they actually suffered fewer of these deaths. Infectious diseases usually killed children. Somehow the fact that Chinese died as adults appeared significant to J. L. Meares. He stressed that nearly a third of the deaths among other nationalities were under age five, while only 35 "Mongolians" of this age died in 1880-81. Adults were held responsible for causing their own deaths and were blamed for immorality or carelessness. But childhood mortality was regarded as unavoidable (see Chapter Five)(S. F. Municipal Reports...1879-80: 414; 1880-81: 251).

#### Summary Chapter Four

During the decade of the 1870s efforts were initiated to document the health of San Francisco's population. Health officials immediately recognized the severe limitations of their statistics. Poor reporting of deaths, confusion in diagnosis and in disease nosology, and the weakness of overall population figures produced very unreliable mortality statistics.

Nonetheless these health officials reported death and disease rates each year and consistently presented San Francisco as one of the healthiest cities in the world, based on such statistics. They referred to a 17/1,000 death rate as a healthful extreme. They attempted to keep San Francisco's at or near this level, even if it meant manipulating overall population at risk figures. Other cities rarely reported a mortality rate as low as San Francisco's. Comparability of such city figures must have been extremely poor, but comparisons did much to assure the public that San Francisco was the healthiest of cities.

Health officials tried to identify the aberrant elements or causes

in the population that sent rates above the healthy level. The Chinese were regarded as one such source of increased disease prevalence and were condemned for it, in spite of little real evidence. Another blamed source of high mortality rates was the city's faulty sewage system. Although only a few infectious diseases (e.g., cholera and typhoid fever) can actually have derived from contaminated water, this concern followed quite logically from accepted etiological beliefs.

A third source of increased mortality rates was the presence of many sufferers of tuberculosis in San Francisco. This disease was not considered to share the features of the zymotic (infectious) disease class. Rather, it was seen as a constitutional, inherited condition. It accounted for the highest percentages of total deaths each year among the diseases we call infectious today. Health officials strongly urged that consumptive patients be removed from city facilities to a state hospital elsewhere. If the city could be rid of consumptives, Chinese, and of its poor sewer system, it would be the healthiest in the world.

#### Endnotes Chapter Four

<sup>1</sup>Logan was born in 1808, graduated from the Medical College of South Carolina and was further educated in Paris. He came to San Francisco in 1850 and lived in Sacramento. He became interested in hygiene and sanitation and believed that medicine should supplement nature. He originated the State Board of Health and was its Permanent Secretary. He was also President of the AMA and of the State Medical Society. He held the chair of Hygiene in the Medical Department of the University of California from 1874 until he died in 1876 of pneumonia (PMSJ 1876 XVIII(10): 491-493; Medical Society of the State of California, Transactions, 1875-76, 6:

136-143).

<sup>2</sup>Logan nonetheless stated that California had a lower infant mortality rate than any other state or country in 1870 (State Board of Health, Second Biennial Report....1871, 1872, and 1873: 34).

<sup>3</sup>The Health Officer was required to keep records of births, deaths and interments filed by sextons, undertakers, cemetery superintendents or anyone else who interred a body. They were also to supply vital information about the deceased, including cause of death. Physicians were also to provide death certificates with this information (Sections 23-25 of An Act to Establish a Quarantine for the Bay and Harbor of San Francisco, and Sanitary Laws for the City and County of San Francisco, approved April 4, 1870. S. F. Municipal Reports...1869-70: 597-598).

<sup>4</sup>Henry Gibbons, Jr. was born in 1840 and migrated as a child to San Francisco with his family. He graduated in medicine from the University of the Pacific in 1863. He served as dean of its medical school and was later professor of obstetrics and diseases of women. He was Health Officer of San Francisco and co-edited the Pacific Medical and Surgical Journal with his father. He died in 1911 (Harris 1932: 240).

<sup>5</sup>The overall mortality rate for the City and County of San Francisco in 1980 was 11.6 per 1,000 (State of California Department of Health Services 1979-80: 21). The idea that 17 per 1,000 was a healthy mortality rate originated with William Farr, the Compiler of Abstracts of the British General Registrar's Office from 1839 to 1880 (Eyler 1979).

<sup>6</sup>John Loudon Meares was born in 1822 and received a medical degree from Jefferson College in Philadelphia. He was a farmer, Civil War soldier and member of the Mississippi legislature as well as a private physician.



He settled in Fresno in 1870 and became San Francisco's Quarantine Officer in 1871. In 1876 he replaced Henry Gibbons, Jr. as Health Officer. He was an authority on smallpox and diphtheria. He died of dropsy in 1888 at age 65 (Medical Society of the State of California, Transactions, 1888, 18: 300-301).

<sup>7</sup>Frederick Winslow Hatch was born, like Meares, in North Carolina in 1822. He graduated in medicine from New York University. He was Secretary of the California State Board of Health after Thomas Logan's death in 1876. He taught in the Medical Department of the University of California. He died in 1884 (Medical Society of the State of California, Transactions, 1885-86, 16: 200-201).

## CHAPTER FIVE: THE CHILDREN, THE FOREIGN-BORN, THE ILL

"One Half the Deaths in a Given Place": Infant Mortality in San Francisco

Table Seven shows percentages of deaths among children under ages one, five, and ten (where available) for each of the relevant years. Deaths of children under five accounted for between 31.8 per cent and 40.1 per cent of all deaths during the years 1867 to 1881 in San Francisco. Those under age one accounted for between 18.3 per cent and 24.4 per cent of all deaths. These percentages represent a very high child mortality rate by today's standards.<sup>1</sup> But they are difficult to assess without information on total numbers of children in the city population. For example, in 1867 and 1869 children under age five accounted for 38.7 per cent and 40.1 per cent of all deaths, respectively. In 1869 smallpox raged; but in neither year could there have been a very large population of children in the city, since women still composed much less than half the population. Large numbers of the children who were in the city must have died during this epidemic.

The Pacific Medical and Surgical Journal produced a short but significant editorial in 1877, rationalizing high infant mortality figures:

That one-half the deaths in a given place should be among children under ten years of age, is startling to the popular sense and often elicits from the newspaper press a doleful commentary on the unhealthful condition of the locality or the insalubrity of the climate, or the inefficiency of medical art. But it is a universal fact and belongs to the laws of life and death. No doubt the mortality among infants might be very much diminished everywhere, by surrounding them with better circumstances. But those better circumstances belong rather to a Utopian condition of society than to humanity with its current errors and vices; and we may expect a different state of things when the millennium shall commence, and not sooner. Fifty per cent. under ten years is really a small mortality, and indicates comparative healthfulness. It is only

TABLE SEVEN: CHILD MORTALITY IN SAN FRANCISCO, 1867-1881

PERCENTAGES OF TOTAL MORTALITY

Year	Under Age One	Under Age Five	Under Age Ten
1867	24.4	38.7	42.2
1869	20.9	40.1	46.1
1870	22.3	37.2	41.0
1871	22.6	32.3	35.4
1872	21.9	31.8	34.5
1872-73	22.4	35.8	33.8
1873		36.5	38.9
1873-74	18.3	33.2	38.7
1874		33.6	
1875		33.8	
1876		34.9	43.2
1877		36.7	48.4
1877-78	23.5	35.7	44.1
1878		34.3	
1878-79	23.4	36.3	40.2
1879		32.7	
1879-80	21.9	32.8	35.8
1880-81	23.1	32.3	35.2

SOURCES: Pacific Medical and Surgical Journal, Mortality Statistics;  
San Francisco Municipal Reports, Health Officer's Report.

the most healthy cities and localities that the mortality is so small in early life (PMSJ 1877 XIX(11): 509-510).

By setting fifty per cent of the total as a small mortality percentage for children, San Francisco was again placed squarely among "the most healthy cities". Clearly these children died from infectious diseases. A high death rate among them, as among foreign immigrants, was accepted as a necessary evil, given human frailty. The victim (or at least the victim's family) was blamed for living conditions and habits that produced disease.

The percentages of deaths under age ten ranged between 33.8 per cent and 48.4 per cent during the decade (see Table Seven). Thus the above quotation implied that the city was in fact very healthful for that age group. Child mortality did not usually even approach fifty per cent of total deaths, except during the smallpox and diphtheria epidemics. The Health Officer reported that infant mortality in 1872 was "indicative of the salubrity of our city....and a more favorable showing it is believed than can be made by any city in the United States" (Gibbons 1873: 422). He went on to state the very important qualification however, that, "Of course we can make no positive comparisons with these places unless we know the proportion of children under five years of age to the entire population" (Gibbons 1873: 422). San Francisco's "salubrity" may have been explained by the simple absence of children in this youthful, male city.

Gibbons suggested again in 1874 that if it weren't for epidemics child mortality would remain at an inevitable, healthful level. Another interesting belief is revealed in Gibbons' analysis of the greater female than male deaths from certain zymotic diseases. He said, "This may be

partially explained when it is recollected that the vast majority of deaths from zymotic diseases occurs among young children" (Gibbons 1875: 438). He may have meant either that there were more female than male children, or that female children were more susceptible to disease (Gibbons 1875: 438; State Board of Health, Third Biennial Report...1874 and 1875: 42-43).

The annual San Francisco Municipal Reports show that children under age five accounted for about half the zymotic disease deaths each year. But the significance of deaths of small children received little attention in discussions of these statistics. They were taken as a matter of course, at least by health authorities. However, an effort to see who these children were began by the end of the decade. It was suspected that they were the children of immigrants, and it was known that they were not Chinese. J. L. Meares' staff prepared statistics showing that of the total 1644 deaths of "minors" in 1879-80 759 (46.2%) were children of foreign parents and another 11.6 per cent had mixed parentage (S. F. Municipal Reports...1879-80: 461).

Henry Gibbons, Jr. was also concerned that the children of foreign-born parents were not identified as such because they were born in the United States. He attempted to use the San Francisco school census to indicate their proportion of the population. He found that 40,056 children under age 17 had foreign parents, 12,230 had native parents, and 5,956 had mixed parentage. He concluded that children of the foreign-born "are greatly in excess in all our cities and towns, especially San Francisco". Considering similar figures, Thomas Logan agreed that "This is simply another proof of the great preponderance of the foreign element" (State Board of Health, Third Biennial Report...1874 and 1875: 36, 43).

Much as both men claimed that the city's child mortality rate was normal, they clearly wished to blame it on the immigrant, not the native population.

"The Laboring Classes": Foreign-Born Mortality in San Francisco

The greater mortality among foreign than native born in San Francisco received frequent notice in health statistics. In 1873 Henry Gibbons, Jr. commented, "Probably in no city in the Union does the mortality of the foreign-born bear so large a proportion to the total deaths ....45 of every hundred decedents in San Francisco during the past year were natives of foreign countries" (S. F. Municipal Reports...1872-73: 343). Most of these deaths occurred in private and public institutions, and among them the Irish and Chinese were prominent. Gibbons commented that "In very few cities do so many avail themselves of such institutions". Most of the patients or inmates were male and foreign-born: "over three out of every four decedents in the various institutions were born outside of the United States" (Gibbons 1874: 488).<sup>2</sup> For example, in 1874 47 per cent of total deaths were of the foreign-born, a third of them Irish and a fifth Chinese. Seventy-five per cent of those dying in hospitals were foreigners: "showing what class patronize these institutions. Let it be understood, however, that about one third of the deaths occurred in the private hospitals...and hence are not charity patients" (State Board of Health, Third Biennial Report...1874 and 1875: 43).

Remembering that during this period almost half of San Francisco's residents were foreign-born, and that four out of five had parents who were, the statistics on foreign-born deaths are not surprising (Cherney and Issel 1981: 29). But it is worthwhile to examine more closely both institutional and Irish deaths reported in mortality statistics.

Of total registered deaths, those occurring in institutions always accounted for a greater percentage than those from specific wards of the city. This percentage ranged from 17.7 per cent in 1870 to 19.6 per cent in 1877. The institutions from which statistics were collected were the City and County Hospital, U. S. Marine Hospital, French Hospital, German Hospital, Italian Hospital, St. Mary's Hospital, St. Luke's Hospital, Small-Pox Hospital, Almshouse, and other charities.<sup>3</sup> Statistics were also collected by wards of the city. Later in the chapter I shall look more closely at statistics from certain wards, and from the City and County Hospital.

Deaths were categorized as Caucasian (or white), Mongolian (or copper or yellow), and African (or black) and Indian races through the decade. But statistics on race of decedents were not very meaningful since it is known that reports on Chinese deaths were extremely inaccurate, and Blacks and Indians were only a very small percentage of the population. Between 1867 and 1881 Caucasians accounted for between 86.3 per cent and 92.6 per cent of total deaths; Chinese for between 5.8 per cent and 12.8 per cent; and Blacks and Indians for between 0 per cent and 1.7 per cent (see S. F. Municipal Reports).

Between 1873 and 1877 the white foreign-born population accounted for between 31.4 per cent and 36.1 per cent of total deaths (see Table Eight). The Irish-born accounted for between 12.1 per cent and 15.3 per cent of all deaths between 1867 and 1880. German-born came next, accounting for 5.5 per cent to 7.8 per cent of deaths. These two populations comprised approximately 13 per cent and 9 per cent of the city total, respectively.

R. A. Burchell (1980) comments that the over-representation of

TABLE EIGHT: MORTALITY OF FOREIGN-BORN IN SAN FRANCISCO, 1867-1881

## PERCENTAGES OF TOTAL MORTALITY

Year	All Foreign-Born	Irish	German	Chinese	All White Foreign-born
1867		13.1	6.9	6.6	
1869		13.0	6.8	5.7	
1870		13.6	7.2	8.8	
1871		15.0	7.8	9.8	
1872	47.2	15.0	7.1	7.8	
1872-73	45.2				
1873		13.5	6.0	10.7	32.1
1873-74				11.6	34.6
1874		15.3	5.5	10.5	36.1
1875		14.5	6.1	11.1	35.3
1876		12.1	6.4	11.7	31.4
1877		13.3	6.2	8.7	32.0
1877-78	49.7	15.6	6.4	9.9	
1878	44.7				
1878-79	47.9	14.8	6.9	11.2	
1879	46.3				
1879-80	48.3	14.3	7.4	10.1	
1880-81	48.0				

SOURCE: Adapted from San Francisco Municipal Reports, 1867-1881



Irish in institutional statistics during this period suggests "a high level of communal dysfunction" for a population comprising only 13.1 per cent of the city (in 1880). But he argues that health statistics should be related to the entire Irish community, including first, second, third, and fourth generations. He finds that all such Irish composed 33 per cent of the city population (Burchell 1980: 155-56). There are several problems with Burchell's argument. His figures on Irish population composition apply only to 1880, and don't explain Irish representation in mortality statistics in 1859-60, when they supplied 27.7 per cent of hospital admissions. Certainly there could have been few second and third generation Irish in the city then. He also looked only at the City and County Hospital and Almshouse for figures on Irish health. There were a number of other hospitals, charities and other institutions that took in Irish, and many deaths did not occur in institutions. For example, the City Physician reported that 120 out of 169 autopsies conducted on those who died in the House of Corrections in 1878-79 were foreigners (S. F. Municipal Reports...1878-79: 251). Finally, Burchell does not provide similar statistics on second and third generation Germans, or other immigrants, for comparison.

It appears that Irish were over-represented in mortality and morbidity statistics. Burchell capitulates a bit when he says that "Part of this sizeable Irish presence in city institutions was clearly the result of Irish poverty". Burchell also argues appropriately that age and sex structure of the community must be considered. We do know that the Irish community included more women, and presumably more children, than other groups did (Burchell 1980: 148-150). Examination consistently reveals that the highest percentages of deaths during the 1870s were from

wards ten and eleven, both highly populated by Irish.

There was contemporary recognition of the extent to which Irish appeared in health statistics.<sup>4</sup> Commenting on tuberculosis (phthisis) in 1875, Henry Gibbons said that the over-representation of Irish must be explained by change in their way of life. He felt that moving from the rugged life of the home country to the comfortable life of San Francisco, rather than poor living conditions in the city, tended to produce this disease (Gibbons 1875: 241-242). He also believed that the Irish demonstrated a proneness to phthisis, perhaps because they drank too much. Unlike an earlier belief that whiskey might be prophylactic for this disease, Gibbons said that it obviously was not (see PMSJ Feb. 1875, 45: 423).

The Chinese population of San Francisco incurred the greatest amount of villification and discrimination. They composed one to nine per cent of the population between 1850 and 1880. By nativity, they accounted for between 5.7 per cent and 11.7 per cent of total deaths during the 1870s, by race between 5.8 per cent and 12.8 per cent (see S. F. Municipal Reports). They were blamed, among other things, for the presence of various diseases, principally tuberculosis and leprosy. The reasons for this anti-Chinese attitude and its consequences have been so thoroughly examined elsewhere that I have chosen not to focus on them (see Miller 1969; Saxton 1971; Higham 1975; Trauner 1978). However, it is interesting to examine the specific comments made by physicians and Health Officers regarding the Chinese during the 1870s. In 1870 C. M. Bates stated that "they are not only a moral leper in our community, but their habits and manner of life are of such a character as to breed and engender disease wherever they reside" (S. F. Municipal Reports...1869-1870:

233). Bates excluded the Chinese when comparing mortality rates of San Francisco to other cities because they "pay no regard to hygiene and sanitary laws; and not only that, but from prejudice, and not speaking or understanding our language, they fail, when attacked with disease, to avail themselves of proper care and medical treatment" (S. F. Municipal Reports, . . . 1870-71: 293). Dr. F. W. Hatch remarked on the Chinese rate of phthisis in 1871 that

their mode of life, in close, dark, diminutive habitations, with imperfect or no ventilation, in many cases in rooms partitioned off in cellars or beneath the street side-walks, where the fresh air of heaven never enters, and to which the pure sunlight is a stranger, the atmosphere continually bedimmed by smoke or the fumes of opium or tobacco, subsisting on dried fish and other unwholesome food - these would of themselves be supposed sufficient to induce disease (Hatch 1871: 28).

In 1877 J. L. Meares also raised the issue, speaking very forcefully against the Chinese as sources of smallpox: "I unhesitatingly declare my belief that this cause is the presence in our midst of 30,000 (as a class) of unscrupulous, lying and treacherous Chinamen, who have disregarded our sanitary laws, concealed and are concealing their cases of small-pox" (S. F. Municipal Reports . . . 1876-77: 397). Meares asked for sanitary legislation giving him authority to clean up "this laboratory of infection". He continued the practice of excluding Chinese from the general statistics since the City Physician could not determine their causes of death (S. F. Municipal Reports . . . 1878-79: 182).

At the end of the decade an editorial finally criticised the common practice of blaming the Chinese for tuberculosis in San Francisco. It said, " a large proportion of the deaths among the Chinese in San Francisco are set down in the official returns as due to phthisis pulmonalis when the cause is really unknown and only suspected". It argued that

"The Chinese are not subject to pulmonary consumption," and that this practice exaggerated the returns on consumption in the city. Concern may have been shifting by the end of the decade away from the "Chinese problem" to the ever-increasing number of tuberculosis cases coming into the city for treatment. It was necessary to show that tuberculosis statistics were exaggerated somehow. Blaming the Chinese for relying on "half-cut practitioners of their own race" so that their causes of death were unknown, had the added benefit of dealing a blow to "quackery" in the city (see Chapter Twelve) (PMSJ 1880 XXIII(7): 322).

Joan Trauner (1978) reports that even in the next decades when bacteriological theories of etiology became more and more accepted, the Chinese were held responsible for epidemics. Their living conditions were blamed. City officials did not finance health care for Chinese San Franciscans until well into the 20th-century. During the 19th-century the Chinese relied on their own herbalists and pharmacies. They were unofficially shunted from the City and County Hospital and Almshouse to a separate building, the Twenty-Sixth Street Hospital. Thus they were, as Trauner argues, subjected to medical scapegoatism, which they were helpless to prevent (Trauner 1978: 70-87).

There was an occasional dissenting voice expressing a different attitude towards the Chinese. An editorial in the Pacific Medical and Surgical Journal took on the Board of Health. It complained that the board alarmed the community by predicting an epidemic of smallpox on the basis of thirteen cases, "and by so doing to interfere with the business and the interests of the community". It continued to criticize the board's blaming the Chinese for the disease: "Just now the Chinese are the focus of Caucasian animosities, and they are made responsible for mishaps in general" (PMSJ 1876 XXII(19): 36-37). Several more editorials

in this journal argued that accusations of leprosy among the Chinese were "a mere bug-bear, got up for sinister purposes" (PMSJ 1878 XXI(4): 179-180; 1879 XXII(1): 33).

### Morbidity

To get a sense of morbidity as well as mortality from disease I have constructed three tables from information reported annually in the San Francisco Municipal Reports. Table Nine shows the number of foreign-born admitted to the City and County Hospital and the number who died there. Table Ten shows the three most common causes of death there each year. Table Eleven shows the six most common diseases of patients admitted each year.

Diseases of hospital patients give an idea of morbidity in the city, but it is a very partial picture. Many patients went to hospitals other than the City and County; and many were treated in other institutions, such as the almshouse, the jail, and many private charities. Hospitals in the mid 19th-century tried to maintain a relatively good reputation by shifting victims of epidemics to a pesthouse and the incurable, "wicked and undeserving" to an almshouse. Hospitals were built initially to care for those who did not have family and social network resources (Starr 1982: 151). People were treated at home more often than not. Many episodes of illness were attended by only self, family, or friends. For this reason I have attempted a tally of illness episodes reported in the primary manuscripts I have researched. This tally is in no way statistically representative of reality, so I have not presented it in table form. But anyone reading such manuscripts today is struck by the simple frequency with which illnesses were reported, and the nature of the diseases.

Table Nine shows that between 1869 and 1880 the percentage of foreign-born admitted to the City and County Hospital was very large and varied little (70-76%). It was a considerably higher figure than the percentage of foreign-born in the city (45-49%). The percentage of deaths in the hospital was also disproportionately of foreign-born (64% in 1873-74 to 75% in 1878-79). As we have seen, the Irish-born appeared most commonly. They accounted for 30-40 per cent of hospital admissions and only about 13 per cent of the city population (see Chapter One). These figures suggest both that the foreign-born (and especially the Irish) took ill more frequently and more seriously than did others, and/or that they were dependent on treatment outside the home.

Table Ten shows the three diseases causing the highest percentages of annual deaths in the City and County Hospital. Clearly the concern expressed in the medical community about the overload of tuberculosis (phthisis pulmonalis) patients was justified. That disease accounted for 27 to 41 per cent of hospital deaths during the decade. Table Eleven shows that tuberculosis accounted for between four and ten per cent of admissions during this period. Thus, it was a highly fatal disease, the "white plague" of the 19th-century (Dubos and Dubos 1952). Syphilis and rheumatism competed with phthisis for the highest number of admissions to the hospital, and malaria closely followed. But these diseases did not cause the greatest number of deaths, which were attributed to pneumonia, heart disease, typhoid fever, and other acute conditions in addition to tuberculosis (Table Ten)

Comparison of death rates by disease in general for the city to causes of hospital deaths shows that most people must have been treated and/or died at home, except those with tuberculosis (phthisis or consump-

TABLE NINE: PERCENTAGES OF FOREIGN-BORN ADMITTED, AND DIED  
SAN FRANCISCO CITY AND COUNTY HOSPITAL, 1869-1881

<u>Year</u>	<u>Total Admitted</u>	<u>Foreign-born Admitted</u>	<u>Irish Admitted</u>	<u>Total Deaths</u>	<u>Foreign-born Deaths</u>
1869-70	2942	75.0% (2205)	39.9% (1173)	240	---
1870-71	2737	76.2% (2086)	35.9% ( 983)	271	---
1871-72	2388	73.2% (1747)	34.0% ( 812)	240	---
1872-73	2863	73.7% (2111)	34.1% ( 973)	260	---
1873-74	3244	74.4% (2412)	34.8% (1125)	275	65.8% ( 181)
1874-75	3918	71.5% (2803)	33.4% (1308)	351	69.5% ( 244)
1875-76	3376	70.8% (2390)	34.2% (1156)	347	71.5% ( 248)
1876-77	3012	71.3% (2147)	29.8% ( 897)	355	69.6% ( 247)
1877-78	3007	69.6% (2094)	31.5% ( 948)	379	69.7% ( 264)
1878-79	3174	70.8% (2246)	30.4% ( 964)	343	75.2% ( 258)
1879-80	2955	69.6% (2058)	32.4% ( 958)	337	71.8% ( 242)

SOURCE: San Francisco Municipal Reports, Hospital Reports 1869-70 -  
1880-81.

## TABLE TEN: HIGHEST PERCENTAGES OF DEATHS BY DISEASES

CITY AND COUNTY HOSPITAL OF SAN FRANCISCO, 1869-1881

Year	Total Deaths	Phthisis	Pneumonia	Heart Disease	Bright's Disease of Kidneys	Typhoid	Paralysis	Cirrhosis of Liver	Tuberculosis
1869-70	240		4.2%(10)	7.5%(18)					25.0%(60)
1870-71	271	34.3%(93)			7.7%(21)	4.8%(13)			
1871-72	240	29.2%(70)		4.6%(11)	5.4%(13)				
1872-73	260	31.5%(82)	9.2%(24)						
1873-74	275	38.2%(105)	8.0%(22)				3.6%(10)		
1874-75	351	35.0%(123)	6.3%(22)	4.0%(14)				4.0%(14)	
1875-76	347	40.9%(142)				4.9%(17)	5.2%(18)		
1876-77	355	39.2%(139)	9.0%(32)			5.6%(20)			
1877-78	379	40.6%(154)	6.6%(25)			5.3%(20)			
1878-79	343	32.4%(111)	6.4%(22)			4.1%(14)			
1879-80	337	31.5%(106)	5.0%(17)						
1880-81	328	27.4%(90)	10.7%(35)						4.9%(16)

SOURCE: Adapted from San Francisco Municipal Reports, Hospital Reports 1869-1881.



TABLE ELEVEN: TOP SIX PATIENT DISEASES  
SAN FRANCISCO CITY AND COUNTY HOSPITAL ADMISSIONS, 1869-1881

Year	Total	PERCENTAGE OF ADMISSIONS					
		Syphilis*	Rheuma- tism**	Phthisis Pulmonalis	Febris Inter- mittent	Inter- (malaria)	Bubo
1869-70	2942	15.4	10.4	4.1	11.3		
1870-71	2737	23.2	6.0	7.6	7.3		2.2
1871-72	2388	13.9	8.0	6.9	4.4		3.6
1872-73	2863	14.7	7.6	7.3	3.3		2.7
1873-74	3244	8.7	9.2	7.6	3.5		
1874-75	3918	4.6	10.4	7.0	5.3		
1875-76	3376	4.0	8.2	8.4	4.9		
1876-77	3012	4.8	8.7	10.0	5.6		
1877-78	3007	4.4	7.2	10.4	5.2		
1878-79	3174	6.4	8.7	7.7	7.8		
1879-80	2955	4.7	4.2	6.4	3.9		2.7
1880-81	3204	4.0	3.1	5.3	3.5		

Year	Ulcera, leg, syphil.		Chancere	Orchitis, Gonorrhoeal	Pneu- monia	Chronic Bronchitis	Alcohol- ism	Preg- nancy
1869-70	4.2						2.3	
1870-71				1.6				
1871-72							2.6	
1872-73	3.0							
1873-74		2.0					1.5	
1874-75		3.2					1.9	
1875-76		4.0					2.9	
1876-77		3.5						2.6
1877-78		2.3			2.5			
1878-79	2.8					2.7		
1879-80		3.7						
1880-81	3.0							3.2

\*Syphilis includes primary, secondary and tertiary degrees.  
\*\*Rheumatism includes acute, chronic, subacute and syphilitic cases.

SOURCE: Adapted from San Francisco Municipal Reports, Hospital Reports,  
1869-1881

tion). Consumption accounted for 11 to 17 per cent of deaths in the city between 1869 and 1877. A high percentage of these people must have died in the City and County Hospital. But the other big killers of these years, including scarlet fever ( 6 to 7% of deaths in 1869, 1873 and 1874), smallpox (6% of deaths in 1869 and 1876), inflammation of the lungs (5 and 6% of deaths in 1870 and 1872), diphtheria ( 9 and 14% of deaths in 1876 and 1877), and others did not demonstrate highest mortality in the hospital. Nor were they common reasons for hospital admission. Typhoid fever accounted for 3 to 4 per cent of deaths generally in 1870, 1871, and 1875. It also accounted for five per cent of hospital deaths for those years, and for a few years thereafter. Both consumption and typhoid were viewed as diseases requiring hospitalization, while other epidemic diseases apparently were not.

#### Diseases in the Wards

The working class, unemployed, and immigrant population (other than the Chinese) lived largely in the wards south of Market Street. Wards seven, ten, and eleven in this area consistently demonstrated the highest death rates in the city during the 1870s. These figures are explained in part by the density of population in wards seven and ten and by the size of ward eleven (see Chapter Three). Ward eleven, with 16 per cent of the city's population at mid-decade, demonstrated between 10 and 19 per cent of deaths annually. Ward ten had 16 per cent of the population as well, and one of the highest densities in the city. This ward accounted for between 12 and 14 per cent of annual deaths. Ward seven was much smaller, had less than half the population of the others, but was densely settled. Its death rate was also lower.

The cause of most deaths in these wards was phthisis, except during

the epidemics of scarlet fever (1873-74) and diphtheria (1876-77). Other key causes of death were inflammation of the lungs; pneumonia; cholera infantum; meningitis; infantile convulsions; and "atrophy, inanition, and marasmus". From 1872 to 1881 sixteen to forty-two per cent of these wards' deaths were attributed to zymotic diseases. The largest percentages occurred during the epidemics mentioned above. These were diseases that affected children, and these were the wards in which children lived. For example, in 1869-70 virtually all the deaths from the scarlet fever epidemic in these wards were among children under the age of ten, while 89 per cent of the phthisis deaths were older than twenty. Ninety-two per cent of scarlet fever deaths in 1872-73 were under ten and eighty-eight per cent of phthisis deaths were over twenty. Similar figures occurred for diphtheria (S. F. Municipal Reports).

That these victims were also foreign-born is demonstrated by Municipal Reports figures. Forty per cent of those dying from pneumonia in the three wards in 1872-73 were foreign-born and forty-five per cent were children under age ten. During the scarlet fever epidemic small children were the victims. Ninety-two per cent were under ten in 1873-74 and ninety per cent had been born after their parents' migration to the Pacific Coast. Many children of the foreign-born succumbed to "atrophy, inanition, and marasmus" between 1873 and 1875, probably because they were malnourished. Diphtheria took a huge number of these young Pacific-born children in 1876-78, ninety-four per cent of them under age ten.

Adult immigrants in these wards died from tuberculosis. Between 1871 and 1881 between fifty-eight and seventy-four per cent of phthisis deaths in these wards were among the foreign-born. Over ninety per cent of these victims were older than ten. The Health Officers recognized the

greater disease rates of these wards, of course. But as we have seen, public health focus was on the sewer system. For example, the Health Officer commented in 1879 that

The improved health of the 11th Ward is a striking evidence of the benefit to be derived from the filling in of stagnant pools of water....San Francisco contains a very large number of tenement and boarding houses. These are too frequently connected with public sewers by means of drains constructed of improper material, without ventilation or efficient traps (S. F. Municipal Reports...1878-79: 178).

Although such complaints undoubtedly had good basis, the improvement of ward health resulted from the end of diphtheria and smallpox epidemics, neither of which were related to the condition of the sewers.

#### Self-Reported Illnesses

Manuscript diaries and letters give an indication of both the frequency and nature of illnesses suffered during the 1870s. The tendency to report illnesses varied from person to person, as did the consistency with which people kept track of them. Nonetheless, examination of these sources is revealing. People often either did not know, or did not care about the diagnoses of diseases. Their concern was with "illness" in ethnomedical terms; i.e., with the psychosocial context of being ill. Many illness episodes were described in general terms: "sick," "feel unwell," "run down," "severe illness," "not very strong," "very low," "sick with fever," "quite ill." The common cold was as common then as today. For example, Amelia Stein recorded in her diary twenty-four colds among fifty-four illness episodes in her family. These colds could be "severe," "bad," "mild," or in the throat or eye (Stein 1878-1886).

Certain informants were susceptible to particular ailments, giving credence to the contemporary belief in constitutional diseases (see Chapter

Nine). For example, a Bay Area society matron suffered all her adult life from an improperly diagnosed condition that involved chiefly sore throats, headaches, and painful heart palpitations. Her diary as a young unmarried woman and her letters as an adult instance twenty-two such illnesses of a total sixty-one illness episodes mentioned among her family and acquaintances (Pierce 1868; 1869-1888). Similarly, a young man in good society who had trouble securing a permanent job suffered from chronic dyspepsia and biliousness. It seems not to have occurred to him that his problem might have resulted from diet. In his diary and letters nine illness episodes of twenty-six mentioned about himself and his acquaintances referred to this condition, which also led to "colic" and "gripes and diarrhea" (Howe 1869-1874).

Other writers were concerned primarily with the illnesses of spouses and children, as well as their own. In addition to the colds she observed in her family, Gertrude Stein's mother recorded among them coughs, diarrhea, measles, swollen tonsils, catarrh, poison oak, headaches, sore throats, mumps, teeth problems, sore feet and arms and ring worm. In all she mentioned fifty-seven episodes of illness in a diary she kept for eight years (Stein 1878-1886). A husband and father might be equally aware of illnesses in his family and among friends. One such noted seventy-six episodes in twelve years. Most were indicated merely by the words "sick," or "unwell". But specific illnesses included smallpox, headache, swollen face and neck, erysipelas, toothache, croup, colds, cholera morbus, neuralgia, boils, consumption, his wife's fatal breast cancer, and various job-related injuries (Galloway 1853-1882).

Frequency of illnesses cannot be determined accurately; but the common experience of ill health a century ago has received inadequate atten-

tion in historical writings. Often the illnesses consisted simply in people feeling weak or tired, having headaches, earaches, sore throats, or aching muscles. Many of these illnesses may have been related to poor nutrition. Neuralgia was a very common complaint, as were catarrh, sore throats, sinus and lung congestion, biliousness, and chills. People also suffered from conditions we rarely encounter today, such as rheumatic gout and quinsy.

Infectious diseases were commonly experienced. Among fourteen informants the following diseases were mentioned among their family and friends: measles (7 cases), erysipelas (5 cases), diphtheria (6 cases), scarlet fever (4 cases), consumption (2 cases), mumps, swollen tonsils, cholera morbus, smallpox, ague, and whooping cough (1 case each). Death was not unfamiliar to these people either. The fourteen informants reported fifty deaths among their relatives, friends, and acquaintances over a period of about twenty years. Although it was a frequent visitor, death was not easily faced. People developed mechanisms for ritualizing and explaining it, as they do today. A thirteen-year-old girl wrote of her mother's courage on learning of the father's death from erysipelas. Both were comforted that one of his last acts had been charitable. Earlier in the same year the mother attended the funeral of a woman and her still-born child. Funerals were elaborate among those who could afford them, and undoubtedly ritualized the expression of grief and horror. In this case the mother reported that the dead woman "looked beautiful her baby was in her arms. Mamma said it looked like marble" (Hyde 1881-1882: May 1, June 22). The man who lost his wife to breast cancer was not able to memorialize her death so easily. He wrote poignantly of her dying in 1877 and of his loneliness for years afterwards (Galloway 1853-1882: Nov. 1877).

The unpleasant mess of many illnesses, their pain and ugliness were not discussed. Rather people identified with the romanticized illnesses of the famous. The tragic lives of stage actors were exemplary, as are those of movie and TV performers today. A society woman recalled Adelaide Neilson, an actress who died one year after her successful appearance in San Francisco in 1877. Her leading man, Henry Montague, also died the following year of a hemorrhage at San Francisco's Palace Hotel. Another actress who played in the city, Fanny Davenport, "died before her happiness and beauty waned". An English actress, Rosina Vokes,

was dying of consumption on her last visit, but few of her audience could have guessed it, she played still with so much verve....Her insistence on playing was not to be overcome....Actors do seem to have a courage peculiar to their calling. Georgie Drew Barrymore played with sparkle and lightness long after her health was broken. She died of consumption in Santa Barbara (Neville 1932: 228).

Still another actress in San Francisco, Clara Morris, was severely ill: "Word of her increasing illness and the terrible remedies employed (hot irons on her spine) heralded her coming every season. In spite of her suffering, she held her audience under her power and moved them to anguish" (Levy 1975: 101; orig. pub. 1937). These examples of courageous illness were made much of in the local press. Like fictional accounts such as Dickens' death of Little Nell, they provided models for illness behavior. Tuberculosis, the great killer, offered an especially romantic picture (Sontag 1978).

#### Summary Chapter Five

During the 1870s children under the age of ten accounted for about thirty-five to forty-five per cent of deaths in San Francisco each year (about 35% were under five and 20% under one). Just as 17 per 1,000

was regarded as a healthy mortality rate, fifty per cent of deaths under age ten was also quite acceptable according to healthy ideology of the time. That San Francisco rarely approached this percentage and other cities exceeded it was indicative of the city's healthfulness. It is hard to know what these childhood mortality figures really meant because we have no estimate of the population at risk.

Most children died of infectious diseases each year, accounting for about fifty per cent of the annual zymotic disease deaths. By the end of the decade efforts were made to confirm the suspicion that the victims were children of foreign immigrants to the city. The forty-five per cent of deaths experienced by the foreign-born corresponded to their percentage of city population: But many children born of immigrant parents were classified as native-born because they were born in California. Thus the actual mortality rate among these families was higher than statistics of foreign-born deaths indicate. The Irish-born tended to be over-represented in these figures. But the Chinese of the city were accused of high rates of tuberculosis, zymotic diseases, and leprosy. In reality Chinese health statistics were extremely unreliable and they were not permitted to use city health facilities.

Other foreign-born used the City and County Hospital and died there. About three-fourths of patients were foreign-born and nearly as many died in the hospital each year. They died primarily of tuberculosis, pneumonia, typhoid fever and heart disease. They were admitted to the hospital most often with syphilis, other venereal diseases, rheumatism and tuberculosis.

Most people died at home. They were usually lower class children and infants succumbing to scarlet fever, smallpox, diphtheria, and other



epidemic diseases. Such children were rarely if ever hospitalized. The immigrant wards south of Market Street demonstrated highest death rates during the decade, children dying of various infectious diseases and young adults of tuberculosis.

The less dramatic illnesses suffered by people in general during this period included colds, catarrh, sore throats, dyspepsia, diarrhea, and headaches, common ailments today as well. Many middle and upper class children suffered "childhood diseases" such as measles, mumps, scarlet fever, diphtheria, and whooping cough without dying from them. One can conclude only that better diet and living conditions provided them with greater resistance than lower class children had. For, as we shall see in Parts Two and Three, neither the regular medical profession nor alternatives offered effective therapies for these diseases. Death was no stranger even to the better classes and its presence was ritualized and romanticized to make it easier to bear.

#### Endnotes Chapter Five

<sup>1</sup>In 1980 in San Francisco children under age ten accounted for 1.5 per cent of total resident deaths; those under age five for 1.3 per cent of the total; those under age one for 1.1 per cent (State of California Department of Health Services 1979-80: 215).

<sup>2</sup>Gibbons usually excluded deaths from foundling asylums from these figures. All were infants of California birth, but many were children of immigrants. There was an extremely high death rate in these institutions because of inadequate substitutes for mother's milk.

<sup>3</sup>By the end of the decade this list increased to twenty-five institutions, including jails, orphan asylums, homes for the elderly, and various

additional hospitals and asylums.

<sup>4</sup>At least with regard to smallpox, Germans were seen as more susceptible than Irish early in the decade. Germans had twice the mortality as Irish from this disease, in spite of the greater percentage of Irish, in both San Francisco and New York. It was believed too, that Germans were more likely to have been vaccinated (PMSJ Sept. 1869, 28: 175),

## PART TWO: "THIS NOBLE WORK": THE REGULAR MEDICAL PROFESSION

## CHAPTER SIX: "REGULAR, IRREGULAR AND DEFECTIVE"

The decade of the 1870s was a formative period for the "regular" medical profession in San Francisco. The contemporary use of the terms "regular" and "irregular" to distinguish members of the establishment from alternative practitioners symbolizes the transition that was taking place. It was a time when professions in general in America were more specifically defining themselves. They were laying down ground rules or codes of ethics, requiring certain evidences of legitimacy such as college degrees, professional certifications, memberships in societies. In effect, they were creating "cultures" of professionalism. Burton Bledstein (1976) argues that "Americans after 1870, but beginning after 1840, committed themselves to a culture of professionalism which over the years has established the thoughts, habits, and responses most modern Americans have taken for granted" (Bledstein 1976: 81).

The ferment in San Francisco's medical world over the previous two decades is a good example of a profession's struggle to define itself, to arrange its power structure, and to gain legitimate authority over the community. Bledstein asserts that this effort was well under way by 1850 in the medical profession. In San Francisco the process was delayed until the 1870s because of its later settlement and the unstable nature of the community. One can say that by then "the status of the struggling medical profession, its ability to control its own members and be recognized as the only legitimate authority by the 'lay' public, had become the paramount issue" (Bledstein 1976: 193). How the culture of medical professionalism was established in San Francisco will be seen in chapters

to come as I discuss alternative practitioners and the ways in which regular physicians reacted to them. First, however, the character of this regular profession in the decade of the 1870s must be drawn.

As many as 1,500 physicians had come to California with the Gold Rush, but their numbers were decimated by disease and departure. The nature of these doctors' training and practice varied widely. A great variety of alternative medical approaches became available as the city grew (Saunders 1967: 309-310). Medical training of doctors at this time was cursory anyway. Before the Civil War it often consisted of six months of academic training and a few years of "preceptorship," assisting a practicing physician. Training thus consisted of "reading with a doctor" and "riding with a doctor". As graduation from medical schools became more common, licensing of those who had served only an apprenticeship was required by many states. But the medical schools themselves were usually proprietary, meaning that they operated to make a profit. They were competitive; and standards for graduation might consequently be low. Course work involved two four-month terms repeating the same material, a final exam and a preceptorship of several years. By the 1870s many medical schools provided clinical training in dispensaries. Some were associated with teaching hospitals. In 1871 Harvard introduced a three year curriculum, and other major schools slowly followed this model (Rothstein 1972; Brieger 1982; on medical education see also Flexner 1910; Berliner 1975; 1980; Duffy 1976; Hudson 1978; Chapman 1979). The practicing doctors of San Francisco in the 1870s were products of medical education that was poor at best and varied greatly with the source of training, European or American. Many had little or no training at all.

This lack of consistent medical education made it all the more urgent for the regular profession to define itself, for the regulars to acquire control and to discredit the irregulars. In 1850 the first ill-fated San Francisco Medical Society began; but it succumbed to disputes over the collection of fees. The medical profession continued to stabilize and legitimize itself as the community itself did. Control over medical competitors became a more central issue as time went on, so that at the reinstatement of the San Francisco Medical Society in 1868, the following statement was made:

Doctors may be classified as Hugh Murray has classed the verbs of our language into regular, irregular and defective. The regulars are those who have respected the custom by devoting years to the study of medicine and have submitted to such proper tests of their ability, as due regard for the common good...is rendered obligatory....The irregulars are such as having studied medicine, and perhaps graduated with honors, have become so lost to every sense of professional propriety, as to proclaim themselves champions of some exclusive idea....Such individuals use the title of 'Doctor' to secure the confidence of intelligent and honest people, whilst they prove recreant to the moral obligations they are under....The defective are those who never had any claim to recognition by the profession....They offer advice and promise a cure of any case in the long catalogue of diseases. These are the unprincipled schemers (quoted in Read and Mathes 1958: 39).

Even then there was a tendency for a three part classification: regular (professional), irregular (popular), and defective (folk).

Listings in the city's business directories indicate the success of the regular medical profession. In 1871 there were four columns of physicians listed, most of them regulars. There were also forty other specific alternative practitioners, including naturalists, botanic physicians, Chinese physicians, electro-magnetic physicians, spiritual physicians, water cure physicians, and homeopathic physicians. There were also listings for female physicians, midwives, nurses and dentists.

In 1876 there were fifty-two of the various alternatives and five columns of physicians. But in 1879 the alternatives had been reduced to 18 and the physicians remained at 5½ columns (Langley 1871, 1876, 1879). These figures do not mean, of course, that alternative practices no longer existed in the city. Their legitimacy had simply been sufficiently damaged to keep them out of the city directory. Details on alternative practitioners will be discussed in Parts Three and Four.

Various medical societies rose and fell in the decades prior to the 1870s, such as the San Francisco Pathological Society, the San Francisco Medical Society reorganized in 1853, and the San Francisco Medico-Chirurgical Association. The California State Medical Society was instituted and survived. There was also a German-Jewish Medical Society in San Francisco. The societies that failed fought over the establishment of fee schedules and definitions of who was and was not a legitimate practitioner (Harris 1932: 122-125; Read and Mathes 1958: 2-24).

By the 1870s San Francisco's economic and social stability was such that permanent societies could be successful. In 1868 a third version of the San Francisco Medical Society had been initiated. The same year the Sacramento Society for Medical Improvement was begun under Dr. F. W. Hatch and Dr. J. G. Tyrrell. These two societies survived (Harris 1932: 127). The city directory lists seven medical societies in 1875 including dental, pharmaceutical, homeopathic, eclectic and regular. In 1870 the California State Board of Health had been established with Thomas M. Logan as Permanent Secretary and Henry Gibbons, Sr. as President.<sup>1</sup> The board concerned itself with the "salubrity of public institutions", with the collection of vital statistics, and with "medico-

social" issues such as prostitution, crime and drunkenness. Besides the collection of statistics, there was little attention given to infectious diseases (Harris 1932: 165, 169). This State Board of Health was only the second in the nation. Meanwhile a San Francisco Board of Health was initiated. It consisted of four physicians appointed by the Governor, thus converting the health department into a powerful political tool of the medical profession.

Two medical schools had been established in San Francisco; the Medical Department of the University of the Pacific begun by Elias S. Cooper in 1858 and the Toland Medical College begun in 1864. In 1870 Toland affiliated with the University of California (Harris 1932: 131-152; Read and Mathes 1958: 25, 58; Jones 1964: 60, 77; Saunders 1967: 310-312; Brieger 1977; 1982). The relationship between these schools was complicated and much conflict was generated by their rivalry.

The internal squabbling of San Francisco's regular profession illustrates Bledstein's contention that professionalization helped "to provide a formal context for the competitive spirit of individual egos". The individualism of 18th-century America had to be tamed and brought into controlling institutions as 19th-century society industrialized. The practice of medicine like other professions had to unify to gain power and legitimate authority (Bledstein 1976: 31; Starr 1982).

The in-fighting of San Francisco doctors was the expression of growth pangs as they gained a professional identity, a means of communication, and the recognized authority of regular over irregular practice (Harris 1932: 127). As we shall see, the definition of those who had a legitimate right to practice medicine based on their official training, and those who were quacks or irregulars was central to San Francisco

thought in this decade. By the 1880s, with the profession established, specialization became the potent issue in medicine. This aspect of professional culture resonates today (Haber 1974; Bledstein 1976: 85; Starr 1982).

"The Routinization of Charisma"

As they organized themselves, San Francisco physicians stressed the difficulty of their work and their poor remuneration. In 1870 the California Medical Gazette commented that 110 physicians' names had disappeared from the original 249 listed in the city directory five years before, and that 123 new names had appeared. At this time there was one physician for less than every 450 inhabitants:

Theirs is a profession where success can only be hoped for by persistence, and the fact that one hundred physicians should annually give up the struggle...can only be accounted for on the theory that they were starved out. Unfortunately the most meritorious men are those who first feel the pressure...while the brazen-faced charlatan, by dint of mendacious assumptions...soon establishes himself in a lucrative business (California Medical Gazette 1870 2: 126).

In 1873 another medical journal wrote defensively about the public service of medical men in the city. The editor noted the salaries of the local members of the Board of Health,<sup>2</sup> and mentioned that professors from the medical schools made daily gratuitous visits to hospital patients. The schools also ran two dispensaries for the poor in which physicians practiced and prepared medicines without charge. The editor argued that 25 professional men performed essential services at an aggregate cost to the city of \$13,200 per year, "not so much as an attorney sometimes receives for a single fee, and but little more than half what is paid in one month for the lighting (so called) of the



streets of the city at night!" (PMSJ 1873 VII(9); 475). It was true that the profession was not a lucrative one (Saunders 1967: 310).

Regular practitioners regarded their profession in the 1870s much as they do today. Medicine was seen as a cumulative, nondogmatic science, distinguished through the ages by great men and works. The medical Code of Ethics laid down restrictions on membership in medical associations. It also defined the obligations of doctors to patients and vice versa. Patients were obliged by the code not to seek other medical opinions once under the care of a regular physician. In fact the code recommended that a physician "ought not to take charge of... a patient who has been recently under the care of another member of the faculty, in the same illness" (Hatch 1873: 96-108).

Physicians nationally and in California reified in their codes of ethics an attitude common to all growing professions of the mid-19th-century. It was necessary to their success that clients trust the professional's authority and expertise. In his or her helplessness and bewilderment the sick person accepted the physician's special and esoteric knowledge, his "command over the profundities of a discipline". The actions, skills, and technology of the physician were mysterious to his patients (Bledstein 1976: 90; Starr 1982).

By insisting upon this mystification about their work, physicians were defeating their own purpose however, to prevent people from turning to "quacks". As long as people remained ignorant of physiology and disease process their choice of practitioner would be based on reputation or charisma. The patient's expectancy about the outcome of treatment is a quality common to healing cross-culturally. A healer communicates his or her potency through various symbols: white coats and stethoscopes

or "drums, bells, masks, antelope horns". The healer must manipulate the patient's expectations so that there is an automatic faith in the efficacy of treatment. The patient must assume that any contradictions he observes between beliefs and practices are the fault of his own ignorance (Young 1976: 10; Rosenberg 1977: 489; Rappaport and Rappaport 1981). The mystique created by the healer is frequently based upon charisma or association with the sacred. The healer is usually not a charlatan, but has convinced him or herself of the ability to heal. The action may become a magical affirmation: "The patient is all passivity and self-alienation....The sorcerer is activity and self-projection.... The cure interrelates these opposite poles, facilitating the transition from one to the other, and demonstrates...the coherence of the psychic universe" (Lévi-Strauss 1967: 177).

The magical, supernatural or extraordinary powers attributed to the healer are charismatic. According to Max Weber, charismatic authority rests on "devotion to the exceptional sanctity, heroism or exemplary character of an individual person, and of the normative patterns or order revealed or ordained by him". This individual authority may become "routinized" when its followers acquire power and economic advantages and norms for recruitment. Charismatic authority becomes transformed into an organization that perpetuates its definition of reality (Weber 1978, orig. pub. 1920s: 215-254).

In the growing professional medical culture of the 1870s charismatic authority lay in exclusive claim to the realm of scientific fact. The disorganized empirical approach that had characterized medical practice could not survive in industrial society. Science provided new calculations for rational man. The charismatic authority of the regular

profession provided it with legitimacy derived from social validation of the superiority of science. Once the identification of medical theory and practice with science was popularly accepted, the regular profession could further secure its hegemony through codification of its rules and enactment of laws defining its power (Shryock 1966a: 71-89; Bledstein 1976; Janzen 1978: 127-128; and see Chapter Twelve).

Starr (1982) argues that the medical profession had to acquire "cultural authority" or command over people's definitions of reality and meaning in order for it to achieve its current status. Its identification with science occurred at a time when health care was changing from a home-based, family-centered function to a commodity steeped in a new scientific ideology permeating society at large. Self reliance in medical care diminished as people became urbanized and isolated from family and social network resources. They began to regard medicine as increasingly complex, as indeed it was.

By the end of the century physicians were able to consolidate around and capitalize upon new perceptions of scientific expertise. These new beliefs coincided with real advances in diagnostic and technical skills as well as the discoveries of bacteriology. The medical profession acquired cultural authority because it became more successfully standardized, transmitted and reproduced. As Starr puts it, social interests began to be defined in a way that conformed to the interests of the regular profession (see also Ehrenreich and English 1978). Janzen (1978) has observed this process cross-culturally and historically (in Zaire). Following Weber, he says that "Growing incorporation within a sector of the medical system always rests on authority received from the surrounding society" (Janzen 1978: 127).

It is important to realize that even the highly sophisticated 20th-century model of biomedicine initiated at this time remains a folk model of disease. Its scientific explanations address the same socially disruptive conditions that any folk model must discharge. The scientific model contains the classificatory features of a folk model; it presents supernatural, mechanistic, empirical, natural, emotional and psychological features. Most physicians commonly negotiate with their patients somewhere between a strict biomedical explanation and popular beliefs; so that their "operational" model is a culturally defined folk model of disease. The textual tradition of professional training is modified by the oral model of folk beliefs through the interaction of physician and patient. Germ theory itself conforms to a folk etiological category cross-culturally, that of either object intrusion or possession (Clements 1932; Polgar 1962: 167; Young 1976: 15; Engel 1977: 196; Helman 1978; Lock 1982).

It is important to recognize also that the discussion above of the charismatic authority of healers applies as well to the popular and folk alternatives to be described in Parts Three and Four. The regular profession was competing desperately with other sorts of healing during the 1870s. As they endeavored to establish prerogative over scientific explanation, physicians reiterated their superiority over patent medicines, "quackery", and other alternatives (see Chapter Twelve). The fight against these competitors was regarded as a high and noble responsibility. As Dr. R. W. Murphy asked,

Who are to be the champions and heroes in this reformation?...we have a principle to defend, as high and pure as ever moved the human heart.... there are great and qualified men in our profession who will move in this noble work with untiring

zeal and energy, and never cease until the light of medical science shall penetrate the gloom and darkness that envelope the people (Murphy 1874: 595-596).

It was necessary in this struggle for legitimacy for the regular physician to maintain his charisma. He must have a scientific image, keeping up with medical developments and displaying a respectable personal style and professional character (Hammond 1879: 212-217; Smith 1879: 542-545).

### Summary Chapter Six

The decade of the 1870s was a time in which the regular medical community was working to achieve hegemony over the city's health care and to establish themselves as the only legitimate health care providers. This effort was difficult in part because of the poor medical training even members of the regular profession had received. From the outset medical societies were formed in San Francisco whose chief purpose was to exclude irregulars or "quacks".

During this decade lasting medical organizations were established in the city and state. Several medical schools were also begun in San Francisco embodying rivalries that were to dominate the profession. The practice of medicine was not particularly lucrative at this time, and there was much competition for patients. Regular physicians regarded their profession as a nondogmatic science. They established a code of ethics for their own and their patients' behavior. Medical practice was mystified to make people regard it and its practitioners with respect and awe. The charismatic authority of individual physicians began to be based on identification with a new general culture that valued scientific approaches. This authority became legitimated as real ad-

vances were made in medical practice towards the end of the century and people became more reliant on outside expertise rather than home-based care. The Code of Ethics enacted in 1876 reified the authority of regular physicians and de-legitimized "quacks". But it was not until the ideology of science was accepted at the popular level that people turned away from alternative practitioners.

Both regular physicians and alternative healers used charismatic authority and mystification of their therapeutic actions to attract patients. The regular profession was not at all secure in its control over the public. Still it ultimately triumphed because "Science as a source for professional authority transcended the favoritism of politics, the corruption of personality, and the exclusiveness of partisanship" (Bledstein 1976: 90). Science was, and is, a powerful symbol, and its reliability has been proven often enough to affirm public faith in it. Once this faith was gained the regular profession had achieved the cultural authority that sustains it today.

#### Endnotes Chapter Six

<sup>1</sup>Henry Gibbons, Sr. was born in Wilmington, Delaware in 1808. He graduated in medicine from the University of Pennsylvania in 1829. He had interests in botany, State medicine and meteorology. He was a member of the California State Board of Health, taught at Cooper Medical College and edited the Pacific Medical and Surgical Journal. He died in 1884 at 76 (Medical Society of the State of California, Transactions, 1885-86, 16: 199-200; Cooper 1885; Harris 1932: 347-354).

<sup>2</sup>The Health Officer received \$200 per month; the Quarantine Officer \$150; the City Physician \$75. There were also on the Board of Health the Resident Physician of the City and County Hospital and of the Almshouse, the Visiting Surgeon and Visiting Physician of the Hospital (PMSJ 1873 VII(9): 474; see also San Francisco Municipal Reports for each year).

CHAPTER SEVEN: "FROM SOME INSCRUTABLE CAUSE":  
BELIEFS ABOUT INFECTIOUS DISEASE ETIOLOGY

The "miasmatic" theory was the predominant 19th-century ideology of disease causation. It was as significant as are bacterial or viral theories today. This explanation traced to Greek humoral theory and the medical ideas of Hippocrates. For centuries Galenic medicine gave continuing authority to miasmatic theory. Its vital feature, the "epidemic constitution of the atmosphere", was further elaborated by Thomas Sydenham in the 17th-century. In brief, the miasmatic theory was the belief that disease is caused by contamination of the atmosphere by "miasms" arising from decayed animal or vegetable matter (Winslow 1943; Pelling 1978: 36-37).

In conjunction with this ideology were beliefs that one disease could give rise to another, or that different diseases could arise from a single source. It was generally held that all fevers were one, simply manifesting itself in different ways. Smallpox was the only infectious disease of which the specific etiology had been established. It was consequently one of the few regarded as contagious for many years (Winslow 1943: 255; Pelling 1978: 250; Rosenberg 1978b: 257).

As industrialization progressed, the poor state of health of the British working population became apparent to such reformers as Edwin Chadwick. The miasmatic theory of disease led to a public health approach. Attention was focused on sanitation, on cleaning up the sources of "filth" which were believed to propagate miasms. Charles-Edward Winslow has observed that

This history of epidemiology is an excellent example of the relativity of scientific theory  
....All that we can demand from a scientific 'law'  
is that it shall 'work' under specified conditions.



The 'great sanitary awakening' of the middle nineteenth century was based on the assumption that disease was generated by decomposing filth (Winslow 1943: xi).

The sanitary movement was effective. It had earlier and greater impact on the elimination of infectious diseases than did the development of vaccines and antibiotics (see Winslow 1943: 236; Dubos 1959: 193-194; Grob 1977: 398; Leavitt and Numbers 1978: 5).<sup>1</sup> Thus strong beliefs and actions in Western science have been as much reliant on observations of their apparent effectiveness as are many of the cures of shamans in other cultures. The theoretical justification for such actions may be inaccurate, but it is reinforced by their success.

There were many etiological interpretations proposed and believed during the 19th-century; variations on the miasmatic theory as well as other proposals. George Rosen's (1958) three-part classification is a useful starting point. It is however, an ideal-type, heuristic classification. There was much overlap and confusion in beliefs:

1. The Miasmatic or Anti-Contagionist Theory held that infectious diseases (i.e., "miasmatic" diseases) were caused by atmospheric conditions in conjunction with miasms created in the filth of urban living or vegetable or animal decay in rural settings. Disease was believed to be locally caused, not contagious. This view was adopted by such renowned members of the public health movement as Edwin Chadwick, Rudolf Virchow and Southwood Smith. The theory was formulated in America by Noah Webster in 1799. It was at the peak of its popularity among Physicians when the advent of bacteriology gave it the lie in the 1880s.

2. The Strict Contagionist Theory was that specific contagia, usually arising from diseased people and their belongings ("fomites"),

caused infectious diseases. Well-known British advocates of this position were William Budd and John Snow. Contagionists promoted isolation of patients and quarantine because they believed the "direct passage of a chemical or physical influence" from one person to another was contaminating (Winslow 1943: 181-201). The general population adhered to the contagionist position throughout the 19th-century.

3. The Theory of Contingent Contagionism was a compromise position that held that infectious diseases were contagious, but only in conjunction with other conditions such as state of the atmosphere, condition of the soil, or social factors. This was a popular theory because it was so flexible.<sup>2</sup> It was adopted by the English public health reformers, John Simon and William Farr, and the German Max von Pettenkofer. The latter's belief that cholera became virulent only in certain soils was a popular view in America (Richmond 1954b: 294; Rosen 1958: 288-289; Wilson 1978: 388).

Erwin Ackerknecht (1948) proposed a since-classic argument about the distinction between contagionist and anti-contagionist theories. He argued that the two positions were closely allied, both being based on unreliable observations, little experimental method, reasoning by analogy, and no understanding of the concepts of carrier or vector. He said the actual choice between the two theories was made for political reasons. Anti-contagionism coincided with the rise of political liberalism among reformers and industrialists. They felt the quarantines dictated by contagionist theory were a bureaucratic attack on free trade. The contagion of such diseases as syphilis, gonorrhoea, smallpox, measles, and "the itch" (scabies) were not denied by these theorists. But they regarded epidemics of plague, yellow fever, cholera and typhoid as non-

contagious (Ackerknecht 1948: 567-569, 585-589; Rosen 1958: 289-290; see also Winslow 1943: 205; 1952: 45). Since San Francisco physicians were almost exclusively anti-contagionist in the 1870s it is impossible to test Ackerknecht's theory there. But nationwide, the annual National Quarantine and Sanitary Conventions had abandoned the idea of quarantines in favor of sanitary approaches before the Civil War (National Quarantine and Sanitary Conventions 1977).

In her sophisticated analysis of 19th-century medical ideas, Margaret Pelling sharply disagreed with Ackerknecht's political interpretation of adherency to one theory or another. She objected also to his dichotomy that all contagionist theories evolved into germ theory, and that all miasmatic theories were anti-contagionist. She argued that all theories were undergoing change, including fungoid, animalcular, and fermentation ideas (Pelling 1978: 299-310).

The three major forces interacting in any of these etiological schemes were atmospheric conditions, local miasms, and contagion from the disease.<sup>3</sup> As we look at representative ideas among San Francisco physicians in the 1870s, Phyllis Richmond's comment is appropriate: "All this confusion of theory and counter-theory was not diminished in any way by the inadequate terminology used at the time" (Richmond 1954b: 294).

The great epidemiological studies conducted in England and Europe at this time took place in a context of changing orientations. The old, formal and abstract philosophical approach to disease theory was replaced by empirical observation and experimental documentation. It is ironic that a chief complaint against germ theory among San Francisco Physicians was that it was "closet speculation" not confirmed by the

empirical evidence of their clinical experience. American culture stressed practical results, not scientific research.

Only about one in seven physicians accepted germ theory in the 1860s, according to Charles Rosenberg (Rosenberg 1978b: 265-266). But by the 1880s the bacteriological era commenced, based on studies initiated between 1877 and 1897 (Rosen 1958: 313-314). Most of these developments took place among the German pathologists. Many laymen and lay publications in America, such as Popular Science Monthly, accepted the theory before professionals did. After Koch demonstrated the tuberculosis bacillus in 1882 however, germ theory became a fad in America. Bacteriological causes were announced for many non-bacterial diseases (Richmond 1954a). But this history goes beyond our time in San Francisco.

"The Pestilential Exhalation": Etiological Beliefs in San Francisco

The locus of most of the etiological speculation and experimentation of the mid-19th-century was England and Europe, not the United States, and certainly not California. Generally, American medical journals reported little of the discussions occurring overseas. Consequently, the miasmatic theory remained entrenched. This conservatism was the result of poor communication from foreign sources, and of lack of professional organization among American physicians. Most physicians' time was occupied by the daily trials of their clinical work. But by the mid-1860s there was, as Charles Rosenberg put it, a "kaleidoscope of etiological and therapeutic variables" in American medical thought. Etiological models were "shifting schemes", including beliefs about heredity, habit, and environment. Because there was so little certainty in etiological thought, immoral behavior was often blamed for causing

disease, especially among the "lower" and immigrant classes (Rosenberg 1967: 232-233). Additionally, climatic conditions held great responsibility in the etiology of infectious diseases.

The attention good 19th-century physicians gave to the complexity of etiology might be emulated today in somewhat altered form. They examined constitutional, environmental and life circumstances as causative factors. The physician even sometimes recognized the role that fear and anxiety had in the patient's condition, although in the case of women this became highly exaggerated (Rosenberg 1967: 234; Smith-Rosenberg 1972; Smith-Rosenberg and Rosenberg 1973; Barker-Benfield 1976; Ehrenreich and English 1978: 91-126). The following advice was offered in San Francisco in 1874:

A CHEERFUL mind is the best preventive for many diseases Dyspepsia, bilious derangements, jaundice, and sometimes a typhoid fever, have resulted from a fit of 'the sulks.' At time of an epidemic, as for instance cholera or diphtheria, fear is often a predisposing cause. It is an old saying, 'You might as well kill a man as to scare him to death' (Homoeopathic Guide for the People 1874: 9).<sup>4</sup>

Medical journals in San Francisco in the 1870s reflected what appeared elsewhere in the United States. A spectrum of proposals and theories appeared in their pages during the decade as writers tried to sort their own empirical evidence from speculative thought transmitted from Europe. A conflict was often expressed between experience and theory, the American doctors tending to rely on the former and reluctant to accept new ideas. By the end of the decade ideas about the bacterial origin of infectious diseases were more common, but still far from being accepted (Richmond 1954a).

Contagionist, anti-contagionist and compromise positions on the etiology of diseases as well as a number of other arguments were being

expressed in San Francisco by the beginning of the decade. In 1869 the medical press summarized the views of Max von Pettenkofer on the necessary ingredients for contagious epidemics:

1. a specific germ; 2. certain local conditions; 3. certain seasonal conditions; 4. certain individual conditions (PMSJ Sept. 1869 No. 28: 176).

The 1870s were not to advance etiological thought considerably beyond this point; but the 1880s revolutionized it.

I have found examples of each of Rosen's types expressed in San Francisco medical journals of the 1870s. Even to be able to think about contemporary medical ideology it is necessary to apply some ordering principle. Of greater significance however, were the repeated assertions and attempts to justify varying and overlapping etiological theories without scientific methodology. Physicians' emphasis on empiricism was a rationalization for their dangerous uncertainty in the realm of theory. It was vital to present a united front if the regular profession was to gain and retain medical jurisdiction.

### Contagionists

Those who believed in disease contagion were in the definite minority. I have found only one real instance published late in the 1860s. The California Medical Gazette compared the current smallpox epidemic to a recent earthquake in the city. It called for prevention of further epidemics of typhus, diphtheria or scarlatina, concluding:

We do not imagine, that any one now denies that these diseases are of a most infectious nature -- that something is communicated from the sick to the healthy; but when we ask what that something is, we are told it is a gas, a solid, a liquid, a germ either vegetable or animal, a poison, or a virus (California Medical Gazette Nov. 1868: 109-112).

There was actually considerable doubt about this belief. Some contagionists were "animalculists", that is, they were able to assimilate germ theory into their understanding of disease. Many others believed that what was contagious was a poison or chemical (Richmond 1954b; 290). When California physicians spoke of "zymotic" diseases they did not accept William Farr's concept of "a substance or specific ferment for each disease" that lived in the body but was lifeless outside it. They referred rather to miasmatic poisons (Richmond 1954a: 436; 1978: 84).

#### Contingent Contagionism

Probably the best local expression of the position intermediate between the contagionists and anti-contagionists was that of Dr. E. A. Kunkler of Placerville in 1879. He wrote that he believed that zymotic diseases were caused neither by fungi nor germs, but that they could be contagious. He believed that minute particles of the exhalations of dead organic matter were inhaled or absorbed by contact, "setting up abnormal processes in the living body". But this effect could take place only under certain climatic conditions and when the victim was in a weakened state. Predisposition could occur through exposure to great heat or dampness which prevented purification of the blood by the lungs. Or cold could prevent perspiration from eliminating the "putrefying ferments". Where Kunkler's theory differed from his miasmatic colleagues was in his statement that zymotic diseases could become contagious when these ferments were "exuded from the skin or lungs". Interestingly, he also argued that "the carcass of one single rat" might become the source of communicable plague, not through fleas, of course, but decay (Kunkler 1879: 49-59).

Miasmatic Theory: Anti-Contagionism

The majority of San Francisco physicians adhered to miasmatic theory and its anti-contagionist position, as expressed by their chief medical journal, the Pacific Medical and Surgical Journal. The editor, Henry Gibbons, Sr., was representative in converting his anti-contagionist position to anti-germ theory when the time came.

In 1868 a San Francisco physician, J. Campbell Shorb, wrote a series of articles on malaria in which he expressed commonly held views on disease etiology. He observed that miasmatic disease, as he called it,<sup>5</sup> was produced by both environmental and man-made conditions. Certain physical laws produced changes on the earth's surface which favored disease; and new immigrants cleared the land, dammed rivers, and brought about other changes that produced putrefied, standing water. Shorb distinguished types of miasmatic diseases to be found in forests, plains, mountains, or cities, suggesting that these environments were so different that the "germ" of the disease must travel from a single source (Shorb 1872: 140). In addition, it interacted differently in different patients. In this idea Shorb was observing correctly the nature of malaria's conformity to the life cycle of the parasite. Symptoms will differ depending on how long the patient has had malaria and what stage he or she is experiencing.

Discussing the "Town Fever" form of malaria, Shorb remarked that it usually occurred in low-lying areas of San Francisco associated with standing water and poor drainage. But he had also observed it "on one of the highest rocky eminences to be found in our city," a result of poor hygiene (Shorb 1872: 395). That ideas preceding bacteriological theory were already present in medical thought is indicated by his vivid



description of a local scene:

Any one whom business or pleasure has taken to the leeward of the Willows, beyond the Mission...will recollect the intensely sickening stench which seemed to load the atmosphere, proceeding from a collection of foulest water....A black, green scum had settled on the surface of the noisome pool, and...we found the waters absolutely quivering with the motions of myriads of animalculae, such as are always found in connection with putrefaction, and we almost shuddered when contemplating the ghastly pestilence, which, rising like a destroying Genius from the putrid waters, might stalk abroad, hurling defiance in the face of medicine, bringing death and desolation to innumerable homes (Shorb 1872: 393).

Again with reference to malaria in 1874, Dr. P. B. M. Miller of Oroville, north of San Francisco, argued for a miasmatic cause. He referred to malaria fairly literally as the common origin ('bad air') of both "intermittent" and "remittent" fevers. But he disagreed that it might cause yellow fever. He remained mystified about why disease occurred in the same place and under the same conditions one year and not the next. But he disagreed that "filth" and smells were the cause. Rather, he felt that the location of Oroville on an alluvial plain with vegetable and animal putrefaction and irrigation resulted in deadly vapors (Miller 1874: 393-395). Thus Miller identified a rural source for malaria.

An editorial in San Francisco that year debated the source of disease in "filth". It reported that a Philadelphia journal argued that use of open cesspools and not water closets and sewers was a healthier approach. Cesspools contained only animal, and not vegetable matter, and only the mixture of the two was seen as fatal. Poisonous vapors also concentrated near homes using sewers because they were not ventilated. The San Francisco editor commented that "no words of ours are needed to call up examples where a sudden puff or a diffusing stream of

vapor rising from the water-closet has produced most serious illness" (PMSJ 1874 XVI(3): 137-138).

Apparently contradicting this position three years later, the same journal argued that diphtheria did not arise from "foul emanations from drains, sewers, water closets". Because it attacked "the cleanliest dwellings, where hygienic laws were strictly enforced", and also appeared in rural areas, this explanation was not possible. But none other was offered (PMSJ 1877 XX(3): 117-118).

A major feature of the miasmatic theory of disease was the ancient concept of an "epidemic constitution of the atmosphere". Specific references to this idea were still being made in San Francisco late in the 1870s. For example, in 1876 and 1877 the prevalence of various infectious diseases created concern. The Pacific Medical and Surgical Journal voiced general anxiety and bewilderment, but said, "There has prevailed for six months or longer, throughout a great portion of the North American Continent, an unusual tendency to eruptive, infectious, and malignant or pernicious diseases....In San Francisco small-pox was followed by diphtheria, which continues to prevail" (PMSJ 1876 XIX(7): 324). Dismissing other explanations, the editor remarked, "We are by no means satisfied with the popular doctrines on the subject, and prefer to confess our ignorance of the causation of most diseases which are placed under the head of 'Zymotic'" (PMSJ 1876 XIX(7): 324). In 1878 a Los Angeles physician was quoted in San Francisco in his belief that diseases were affected by "some inscrutable telluric or meteorological cause, or from a peculiar constitutional diathesis of the whole human race" (Dalton 1878: 347).<sup>6</sup>

The next year Henry Gibbons, Sr. continued to express an epidemic

constitution idea in his explanation of the arrival of cholera in California in 1850. It required "a certain epidemic influence" to travel, and such a "choleraic cloud" had accompanied immigrants across the country that year. He said that both cholera and yellow fever might be prevented by sanitary measures, however (Gibbons 1879b: 87-90).

Typhoid fever and diphtheria were similarly placed squarely in miasmatic and anti-contagionist ideology. In 1879 it was claimed that "there is nothing in all the range of medicine more certain and demonstrable than the causation of typhoid fever and diphtheria". They resulted from decaying organic matter, often carried in water or milk (PMSJ 1879 XXII(2): 80). Typhoid was infectious, not contagious. It resulted from "the continued operation of the original cause, the victims succumbing all to the same local influence" (Gibbons 1879a: 106).

#### Anti-Contagionism

Specifically anti-contagionist statements appeared in association with miasmatic theory from the beginning of the 1870s. Referring to a proposed European conference on scarlet fever, an editorial in the Pacific Medical and Surgical Journal said in 1869, "We suspect that much more good is to be accomplished by adopting measures of general hygiene than by efforts directed against the spread of the disease by contagion" (PMSJ Dec. 1869 No. 31: 329). The editor, Henry Gibbons, Sr., was aligning himself with the sanitary reformers and against those who advocated quarantine and other measures of isolation. The same journal argued against the belief that phthisis (tuberculosis) was communicable in 1872. Nurses who were constantly around such patients did not get the disease. Family members who became tubercular did so because they

had weakened constitutions and were exposed to "the foul emanations from diseased and suppurating lungs", not a specific, communicable "virus" (PMSJ 1872 VI: 449-450). This statement is an example of what Erwin Ackerknecht meant when he argued that contagionist and anti-contagionist views were really very close.<sup>7</sup>

The yellow fever epidemic in other parts of the country in the late 1870s aroused concern in the San Francisco press.<sup>8</sup> The contagionist interpretation of this disease was condemned in San Francisco in 1877 and 1878. The fact that northern cities were free of the epidemic was attributed to its being local in origin and avoidable where scrupulous sanitary precautions were taken. The disease resulted from "an epidemic influence, atmospheric, telluric or personal; or to some mysterious and intangible condition of men and things, which underlies all epidemics and epizootics" (PMSJ 1878 XXI(4): 178). Especially during this epidemic which devastated the southern states, a distinct expression of dread appeared in the daily San Francisco press, and in medical journals. In spite of the mystery of yellow fever's cause, however, the editor of the Pacific Medical and Surgical Journal maintained a staunch anti-contagionist position: "As a general rule, writers who have had the least personal experience adopt the idea of contagion most readily; while practical men, who have seen, and handled, and become familiar with whatever disease is in question, are more apt to deny its communicability" (PMSJ 1877 XX(4): 115-116; see also 1878 XXI(5): 222). In 1880 he reiterated this position on yellow fever; that theoretical analysts regarded it as imported (and consequently responsive to quarantine), but those with empirical evidence saw it as having a local origin (PMSJ 1880 XXII(8): 376-377).

People in general did not share the anti-contagionist view of yellow fever. A Mrs. Hare and her four children were quarantined away from San Francisco in 1878. The eldest daughter died of the disease while on an emigrant train from Memphis to that city. Railroad officials decided to quarantine the family and another woman in their car, hoping the cold nights would kill the contagion (San Francisco Chronicle Sept. 7, 1878: p. 1, c. 1).

In 1880 a meeting of the San Francisco Medical Society brought together the three etiological perspectives that were on stage when germ theory made its memorable entrance. Ironically, the physicians did not even react to the real purport of the paper they discussed, but expressed instead their traditional biases. The paper, by Dr. W. H. Mays, argued that all diseases resulted from human communication of living germs. Most of the eleven doctors who commented supported the theory that various diseases may arise from a single source (miasmatic theory). In their personal experiences they had observed erysipelas and puerperal fever communicate into each other (the transmutation of diseases), and scarlatina, diphtheria and erysipelas derive from a single source. Three doctors rejected this unity of origin theory. Dr. Gibbons, the most ascerbic critic of contagionist and germ theory in the past, adopted a moderate position at this time. He said that some infectious diseases arose de novo and that germ theory was possible. But he felt the germs might arise outside the human body. He remarked:

It is not easy to believe that the vaccine crust which I introduce in a child's arm owes its powers to living organisms--nor that the virus of serpents or of hydrophobia is a living creature....When I was a young man I swallowed all the new theories with a keen relish, but in the course of time I had to throw up most of them (PMSJ 1880 XXII(12): 557-559).

In this case Gibbons was eventually forced to digest. But as I discuss germ theory shortly and its opponents in San Francisco, his antagonism will be evident.

"Do Odors Cause Disease?"

Before discussing the advent of germ theory in San Francisco, the limitations of Rosen's tri-part categories (as previously noted) should be shown by examples of some other etiological theories appearing there in the 1870s. For example, one of the earliest editorials of the decade on etiology asked, "Do Odors Cause Disease?" The editors concluded that they do not. They argued that San Francisco's Butchertown was no more unhealthy than Rincon Hill, "or the ever-fresh and breezy range of Van Ness Avenue", and that the waterfront, "where the intestinal canals of the city are defecated" was not more liable to epidemics. They went so far as to say that "germs of disease capable of producing the most deadly disorders, are more apt to abound in an atmosphere which is clear, pure, and sweet" (PMSJ Sept. 1870 No. 40: 179-180).

In a confusing editorial the following year one of the journal's correspondents took issue with the idea that because sewer workers did not get ill, sewer exhalations were harmless. He felt that such workers threw off sickness only because they perspired. Providing examples of people being sickened by other "stenches" such as tobacco, he argued "I would rather risk advocacy of the poisonous or deleterious character of all foul odors a priori, than the other side" (PMSJ VI(7): 343-344).<sup>9</sup> In a typically confusing way, the journal had thus editorialized against and for the danger of odors in a two-year period.

In 1873 the views of an Atlanta doctor on pulmonary tuberculosis

were published in San Francisco. His ideas are surprisingly modern, for he proposed that there was a hereditary predisposition to the disease. This inheritance might be passed through the circulation of "tubercular corpuscles, germs or cells" in the blood and tissues. In addition there were constitutional or congenital bodily conditions that predisposed to the disease, such as "a perverted and depraved action of the nutritive function". This physician concluded that living conditions were crucial to predisposition to tuberculosis ("a diathesis of the constitution"). He mentioned such things as hygiene, diet, over-crowding, long work days, uncomfortable dress and "self-abuse" (Griggs 1873: 582-587).

Both moralistic and genetic theories of disease were expressed in 1874 by O. M. Wozencroft. He argued that there should be a "quarantine" preventing marriage of those who had a "seed of scrofula, tubercle, or syphilis". If such people did produce children, "enfeebled, suffering, short-lived beings, distressing to humanity", it was the parents' moral responsibility to care for them, "an ever-present, living memento of folly and sin" (Wozencroft 1874: 395-397).

An article in 1878 claimed a climatic origin of malaria in a hot/cold theory of etiology. The author disputed the belief that malaria was a poison from decaying vegetable matter, like cholera. He argued instead that "malarial disease is a chill following exposure to cold, caused by radiation or evaporation" (Hittell 1878: 149). Thus prevention involved avoidance of chilling. Dr. M. M. Chipman challenged this argument point by point a few months later. He agreed that chill might bring on malaria, but only when "the germs of the disease" were already present in the system. He subscribed to miasmatic theory, that

malaria originated in the decay of vegetable and animal matter in the soil. When it was disturbed, "morbific influences" were produced (Chipman 1878: 198-202).

That same year the medical press reported the belief that tuberculosis resulted from alcoholism. And it rejected the proposition from China that elephantiasis resulted from mosquito transmission through the human bloodstream (PMSJ 1878 XXI(5): 237-238; XXI(7): 326-327). This may have been one of the first nearly correct explanations of vector transmission of an infectious disease.

#### Contagium Vivum

We find a sudden "fermentation" in the medical press of 1879 and 1880 concerning infectious disease etiology. Various forms of germ theory were appearing. In the first month of 1879 the "unanimous opinions" of the Medical Corps of the Navy were reported in San Francisco that "yellow fever is due to a specific living germ--the vitality of which may be impaired or destroyed by extreme cold, and which rapidly propagates itself when deposited in a nidus of visible or invisible filth" (PMSJ 1880 XXI(8): 376-377).

Before this "official" confirmation of the reality of germs many ideas of "animalculae" had been expressed. By 1850 in America the early medical geographer, Daniel Drake, expressed his belief in them. He said that both malaria and cholera resulted from living organisms (Drake 1850; Dunlop 1965: 43). But this idea was to receive very slow consideration in California (Harris 1932: 162; Thompson 1971: 125).

"Germ theory" is defined by Phyllis Richmond as "the notion that a living agent of contagious matter might be the specific causal factor in a wide range of transmissible diseases. By 'specific causal factor'



is meant the environmental factor or 'remote' cause--cause outside the body--without which there could be no diseases" (Richmond 1978; 84). Although it took many years for germ theory to be accepted in the United States, the idea dated as far back as the invention of the microscope. Many 18th-century European scientists found the idea of microscopic insects or worms a better explanation for the transmission of disease than prevailing theories. Few proponents of the idea surfaced in the United States however. Cotton Mather was an early advocate in the 1720s, but aside from Daniel Drake, few others wrote of the animalcular theory there until the late 19th-century. The reason for its slow acceptance was in part because disease taxonomy was so confused. Disease entities were not clearly identified, much less associated with specific causes. The anti-contagionist position further blocked the notion of germs in the United States and Great Britain. These countries developed successful sanitary reform programs partly because of the lack of interest in specific germs or contagion. Germ theory was accepted in America only after techniques and equipment became available in the late 1870s and 1880s to demonstrate specific causation of disease by microorganisms (Shryock 1972).

Dr. Gerard Tyrrell of Sacramento was an early local advocate of this viewpoint. He presented an argument predicting the bacteriologic era in 1873. He rejected explanations for disease such as "Dr. Graves' telluric influence" and "Schonbein's Ozone theory", or the idea that the electrical condition of the air was responsible. He said,

The latest solution of the mystery...is to be found in what is called the Germ Theory of epidemic disease. Tyndall has demonstrated that in the air we breathe, millions of germs of every description always exist, and are wafted from place to place with every change of

wind...sowing the disease wherever the poison-laden air comes in contact with individuals susceptible of infection....It is true that we are not as yet able to isolate the germ of one disease from that of another, neither are we indeed able to say what is a disease germ and what an innocuous molecule. The time is coming when these things, infinitesimal in size but giants in revelation, which now puzzle the scientific mind, will lay their storehouse open...when these sudden visitations, which are now like the dread spirit that in olden times passed over the Egyptians, leaving one dead in every house...will no longer be a subject of wondrous mystification or unreasoning terror; when science shall present the cause...and with the cause the remedy (Tyrrell 1873: 224-225).

Tyrrell's prophetic understanding of bacterial etiology seems sensible to us today. But it was regarded as quite impossible by most of his contemporaries for the rest of the decade, and well into the 1880s.

At the end of 1879 Dr. J. H. Wythe of San Francisco summarized various prevalent etiological theories at the Anniversary Meeting of the San Francisco Medical Society. His talk was entitled, "Disease-Germs". He argued that diseases once regarded as products of fermentation or poison resulted from contagium vivum. He remained skeptical as to whether miasmatic diseases as well as contagious diseases might be so caused ("contagious" diseases usually referred to smallpox, measles, and venereal diseases). He divided germ theory into two types. The first was "The theory of vegetable parasites in the blood, generally fungi, and of this class most commonly the various species of Bacteria," from German pathology. He favored a second type: a bioplasmic or cellular theory of one Dr. Lionel S. Beale. Whichever position was accepted, Wythe argued, public hygiene and antiseptic treatment were effective (Wythe 1879: 1-10).

Anti-Germ Theory: "Dreaming of Infantile Megatheriums"

Meanwhile, most San Francisco physicians completely opposed the

idea of living disease germs. The Pacific Medical and Surgical Journal was staunch in this regard. In 1872 it disputed the reported findings of "animalcules" in buttermilk that had made a family ill. The journal would not accept that these organisms had come from the cow (PMSJ 1872 VI(4): 196-197). In 1873 the same journal again questioned that germs seen by microscope in milk led to typhoid fever. Again they wondered why the cows were apparently unaffected (PMSJ 1873 VII(6): 294). The editors argued against germ theory again in 1878 and cited various supporting studies. In 1879 they declared the "germ theory in doubt" because another medical journal reported a fungus source for yellow fever (PMSJ 1878 XX(8): 364-365; 1879 XXI(12): 572). Again focusing on milk as a carrier of germs, this journal published an ironic piece rejecting a British argument to that effect:

Soon there will be nothing left for us to eat or drink without swallowing the seeds of disease and death. We shudder to think of the myriads of organisms which enter the lungs with every breath of air. We dare not drink water....We do wish that doctors and other scientists would stop this over-stocking of all nature with microscopic perdition....Let us draw a long breath without terror. Let us eat our bread without apprehension.... Let us enjoy a drink of cold water when thirsty, without dreaming of infantile megatheriums and dinotheriums entering the stomach (PMSJ 1880 XXII(2): 78).<sup>10</sup>

A few months later a writer urged physicians not to ride this latest hobby horse in medicine, but to think independently (PMSJ 1880 XXII(4): 197). But an article in the publication Nineteenth Century had argued late in 1879 that the microscope proved the presence of disease organisms in typhoid fever. The medical press in San Francisco commented in "The Germ Theory on Stilts" that "The germ theory is now under fire, and looks like losing ground rather than gaining it". Germ theory was simply "closet speculation" (PMSJ 1880 XXII(7): 332). The

article contended that contagion took place through the passage of minute solid particles through the air and into the lungs. Several months after rejecting it, the San Francisco editor, Henry Gibbons, Sr., apparently accepted the theory and began to debate its advocates on their own ground. He was astonished that the article proposed that the particles were irregularly scattered in the air, "like so many flies or mosquitoes, which may or may not alight on a nurse or visitor". Rather, he argued, there were thousands of specific germs in the air. Only an innate immunity prevented those present from becoming ill (PMSJ 1880 XXII (9): 422-424).

Just two years earlier Gibbons had argued against germ theory as he had against contagionism, that it was based on "superficial observation": "Hence the study of zymotic diseases in the closet, amid visions of bacteria and microscopic germs, is more apt to develop the doctrine of contagion than direct observation and personal experience in the theater of practice" (PMSJ 1878 XXI(4): 179). Henry Gibbons, Sr., in his early seventies, is a key informant in that he epitomized American medical thought during this period, conservative in theory as well as practice. But by 1880 he was reluctantly considering bacterial causes of disease.

Dr. T. A. Snider of Sacramento presented a clear summary of the different etiological explanations of zymotic diseases in late 1880. Snider said that "The bacterian theory is rapidly being disproved and abandoned, and the theory that these diseases have each a distinct living germ still lacks that confirmation which will induce the thinking, practical physician to adopt it" (Snider 1880: 249). For example, John S. Hittell

reconfirmed his 1878 argument that malaria originated in a chill. He rejected in 1880 the report of two European doctors that malaria was caused by a Bacillus malariae, a "microscopic plant or animalcule found in swampy soils" (Hittell 1880: 553-555).

#### Summary Chapter Seven

Etiological beliefs that were typical of American medical thought of the time were expressed in San Francisco in the 1870s. The old miasmatic theory predominated, with its accompanying anti-contagionist position. Infectious diseases (then called "miasmatic" or "zymotic"), both rural and urban, were believed to derive from local sources of decaying animal or vegetable matter. Disease was created from resulting miasms joining an "epidemic constitution" in the atmosphere. Some San Francisco physicians adopted a "contingent contagionist" position, believing that the miasms were potent only when certain other environmental or climatic conditions, or bodily predispositions were present. Fewer physicians adopted a strict contagionist theory that some poisonous character of disease could be directly transmitted from person to person, or through affected belongings. The term "germ" was frequently used in these writings, but its meaning was vague and did not refer to the bacteria and viruses to be identified later. It might be a chemical or poison, an element, or a "zyme" or partly living substance. The success of miasmatic theory was guaranteed by the relative effectiveness of sanitary reform measures. As urban "filth" was cleaned up, the prevalence of such diseases as cholera and typhoid was in fact affected for the better.

The variety of etiological theories present during this decade reflected a dynamic period in scientific thought and therapeutic

approaches. Beliefs in predisposing immorality leading to disease produced accusations from upper and middle classes and some physicians that immigrants and the poor were responsible for infectious disease epidemics. It was not until the end of the century that physicians and scientists, laboring under the traditional philosophical approach to disease theory, recognized what people in general had empirically observed; i.e., the communicability of infectious diseases. It is ironic that advocates of miasmatic theory in San Francisco insisted that their empirical observations were more reliable than the "closet speculation" of experimental science. Physicians and their patients were obviously making different observations since the doctors could find no evidence of communicability and lay people could.

Although the idea of "animalcules" or little insects or germs filled the intellectual atmosphere of the late 1870s, very few San Francisco physicians accepted them. As in the case of the anti-contagionist position, the feeling was that this theory derived from scientific experimentation, not from practical, on-the-job observation. By 1880 leading medical men of the city were having to consider bacterial theory more seriously. They were still inclined to reject it.

#### Endnotes Chapter Seven

<sup>1</sup>Thomas McKeown (1976) argues that improved quality of food and increased efficiency in its distribution led to greater resistance to infections and the consequent decline in diseases before the bacteriological era.

<sup>2</sup>We still do not know what causes epidemics to occur at certain times and places. They are not explained by infection alone. "There is still

a basically unknown 'X factor' in epidemiology" according to C-E. A. Winslow (1943: 233; 1952: 49).

<sup>3</sup>In a three-part classification of 19th-century ideas, Phyllis Richmond (1954a) distinguished atmospheric, chemical, and miasmatic theories. The atmospheric theory stated that the atmosphere is corrupted by diseased persons and their fomites. The chemical position of John Snow was that disease discharges communicated poisons. The miasmatic theory was that contagion occurs when these discharges decompose (von Pettenkofer). Under the influence of Justus Liebig's chemical experiments, William Farr proposed his zymotic theory. This argument defined a ferment or "zyme" specific to each disease that reproduced itself as a living organism in the body. The term "zymotic" was used in America for what we now call infectious diseases, but Farr's theory was not adopted (Richmond 1954b: 296-298; Eyler 1979: 100-107). For etiological schemes embodying these concepts in the 15th to 18th centuries, see Winslow (1943). Such concepts could be compared to etiological classifications established by ethnomedical studies of other cultures (see Rubel 1960; Nurge 1977; Willis 1977).

<sup>4</sup>Early etiologies of disease did not distinguish the psychic and somatic, so moral or psychological factors were seen as contributory. Fear might be regarded as a predisposing factor. This idea should be compared to modern anthropological studies of susto (see Rubel 1977).

<sup>5</sup>Shorb distinguished between miasmatic diseases as "the pestilential exhalation" arising from "the stagnation of fresh water over animal or vegetable matter in a state of decomposition;" and malaria as the more specific term referring to "poisonous matters...from...defective

drains, choked sewers, foul sinks, badly-ventilated or over-crowded dwellings". Malaria was also the character of the air affected by miasms (Shorb 1872: 76). The fuzziness of these distinctions is typical. I have quoted from the 1872 reprint of these articles. They appeared originally in the California Medical Gazette in July-Nov. 1868, Jan. 1869.

<sup>6</sup>Telluric: "of or belonging to the earth, terrestrial; pertaining to the earth as a planet; also, of or arising from the earth or soil".  
Diathesis: " A permanent (hereditary or acquired) condition of the body which renders it liable to certain special diseases or affections".  
(Oxford English Dictionary).

<sup>7</sup>In 1879 the distinction between "contagious" and "infectious" diseases had been stated as follows: "There is certainly a difference between a disease which spreads indefinitely and is carried by individuals from place to place [contagion], and one which is confined to certain limits and is not transported beyond those limits by persons affected with it [infection]" (PMSJ 1879 XXII(2): 75).

<sup>8</sup>On yellow fever, see Powell 1949; Duffy 1966a,b; Carrigan 1967, 1970; Ellis 1970, 1977; Wishnow and Steinfeld 1976; and Goodyear 1978.

<sup>9</sup>One slogan of the miasmatic theorists was that "all smell is disease," referring to the decaying sources of miasms. It is probable that they did not mean that smells themselves were dangerous, but they were no doubt often taken literally (see Pelling 1978: 2). It is not unusual in the history of health ideas to find the opposition of clean and unclean associated with pleasant and unpleasant. The use of a deodorant to erase bad odors might easily become a disinfectant to destroy dis-



ease, as we often see in modern advertising: "a confusion of science and aesthetics" (Temkin 1953: 462). Such ideas are expressed cross-culturally (Douglas 1966).

<sup>10</sup>This "soon there will be nothing left for us to eat" argument is strikingly similar to complaints made today by those who say that if "everything causes cancer" there is no point in avoiding food additives, preservatives and other carcinogenic chemicals.

## CHAPTER EIGHT: THERAPEUTICS: NATURE VS "HEROICS"

Debates about the etiology of infectious diseases in the 19th-century had little or no impact on physicians' day-to-day practice of medicine. Charles Rosenberg (1977) has discussed the relationship between medical theory and practice of this period. He points out that therapeutics involve more than physical manipulations. Cultural factors including personal and social characteristics of both physician and patient interact to produce the context of medical care. The ways in which this process occurs are regulated by traditional social rituals (e.g., see Emerson 1970).

Nineteenth-century therapeutics have been described both as part of a progressive evolution in medical knowledge and as the product of economic market-place competition. Rosenberg notes however, that these explanations refer only to changes in medical ideology. They do not explain the relationship between medical theory and practice. He argues that therapeutics resulted from a metaphorical understanding of the human body as a balanced system. The body was continually juxtaposed between inherited constitution and environment. An equilibrium model explained the balance in its functions which equalled health and the disturbance which caused disease. Balance could be affected by both internal bodily chemistry and external factors such as miasms and climatic change.

Physicians relied on this common cultural understanding of health when they treated their patients. Natural functions of the body such as perspiration, urination and defecation became central signs of both disease and the effectiveness of treatment. The physician's equipment consisted primarily of his basic sensory abilities to observe these functions in the absence of more sophisticated technology. Drugs were de-

signed to affect these functions as well. Thus cathartics and emetics were used in both regular medicine and popular and folk practice. The equilibrium model of health and disease was shared by regulars, irregulars and lay people alike. It was akin to the popular conception of wholistic health today (Chapter Nine).

The public health movement was to have greater impact on infectious diseases than any medical therapeutics (see Chapter Three). But it was the rare physician who encompassed both a preventive and curative approach to disease. Most regular physicians occupied themselves with the details of current materia medica, as they do today.

"Heroic" medicine still reigned in early 19th-century medical practice in both hospital and home treatment. It was based on a theory of rigorous treatment to counteract virulent symptoms. Treatment involved bloodletting, blistering, emetics, purgatives, opiates, and meager diet. These active therapeutic measures declined in use generally by 1860, but claimed ardent advocates in San Francisco well into the 1880s. Some of the major medicines of the heroic approach, such as calomel and tartar emetic, were shown to be ineffective by experiments in the 1860s. But few San Francisco physicians were impressed by the experimental methods developed by the Paris School. They preferred time-honored approaches (Powell 1949; Berman 1978; Duffy 1982).

Patients could readily observe the effects of heroic medicines. They knew they were receiving treatment and were reassured, despite unpleasant side effects. The popularity of certain ingredients of regular as well as alternative and patent medicines followed from this affirmation by physiological response. As is the case with such diseases as cancer today, there was no necessary connection between etio-

logical theory and therapeutics. The imbalance of disease was evident from physiological symptoms, and these symptoms were treated by drugs or bleeding to reestablish bodily equilibrium. It was important neither to designate specific diseases nor to prescribe disease-specific cures. The etiological theorist and the practicing MD had little need of each other.

Where alternative practitioners and regular physicians disagreed was on the means of bodily restoration. By the 1870s eclectics and others emphasized the natural healing capacity of the body, helped by proper diet and exercise. They rejected the *materia medica* of the regulars, but not their understanding of health and disease (see Part Three). Few regulars or "irregulars" were ready in the 1870s to accept the idea of specific disease entities. Rather certain constitutional susceptibilities and certain environmental influences resulted in specific physiological responses. In a sense, specific diseases were not treated. Bodily imbalances were the object of therapy. This approach did not emphasize prevention to the extent that wholistic health advocates do today. But these present-day alternatives allow the 19th-century view of the body to survive in popular conceptions of health and disease. The regular practitioner no longer shares this viewpoint, although some medical critics suggest reintroduction of a "systems" view of the body (Engel 1977). Today regular practitioners must rely on the charismatic authority of modern science to persuade their patients to comply with their advice, for they can no longer rely on a shared definition of health and disease (Rosenberg 1977). Physicians treat "disease" not "illness", in the ethnomedical sense. This change began among San Francisco physicians in the 1870s (see Chapter Six).

"Violent Perturbating Remedies" vs The Power of Nature

Heroic medicine had little to offer against disease, but its drugs were commonly experienced by anyone seeing a regular physician until late in the 19th-century. Treatment was accepted by patients generally because patients and physicians shared a common conception of health and disease and the human body. Evidently these remedies "worked" because they produced significant physiological responses. As long as patient and physician shared this understanding of illness these therapeutics met social expectations, and illness, if not disease, was satisfactorily treated (Young 1976: 7-8; Rosenberg 1977b: 491). With the growing change in medical ideologies of the 1870s however, more people became disillusioned with heroic techniques.

People sometimes expressed their opinions of medical care in their letters or diaries. For example, Helen D'Apery recalled her treatment as a schoolgirl in Oakland for diphtheria. She was weak and could scarcely eat or walk:

and then Dr. Porter was sent for, and he dosed me well, after the generous ideas of Allopaths, and after a couple of weeks of rather strenuous treatment he ended by bringing out a bottle with a beautifully colored crimson medicine, and I was to take 3 doses daily, a teaspoon full in a glass of hot water and as much sugar as I liked. I never tasted anything so hot in my life before or since. It was some sort of tincture of cayenne pepper. The tears would roll down my face and I would have the hiccoughs for an hour each dose, but I got well, especially as the old doctor put a ban on candy and the other unwholesome material I had been eating (D'Apery ca 1852-1872: 421-423).

Although this experience with heroic medicine occurred in the mid-1850s, D'Apery underwent even more unfortunate heroics in the early 1870s. As a woman in her late twenties, she went to help a mother whose child had died of scarlet fever. On her return she got quite wet in the rain,

but did not change her clothes. The next day she had "what the doctors said was typhoid pneumonia." She recovered, but came down with inflammatory rheumatism after again going out in the cold and fog. She spent many months in bed, unable to turn over:

By slow degrees, and under the influence of acid medicine which eventually ruined my teeth, the swelling all seemed to concentrate in my left knee. That swelled as large as my head and such acute agony I never wish to experience again....I could not tell the tortures they put me to try to 'reduce the inflammation'....If I had had the right kind of treatment I might have been saved the blight that fell upon me, but doctors of today--well what is the use? It is done (D'Apery ca 1852-1872: 580-587).

The doctors finally told her "that the long continued fever heat in that joint had dried up all the synovial fluid, and the cartilages had hardened to one solid mass, and I could never straighten that knee again". She was extremely bitter and resentful about this outcome (D'Apery ca 1852-1872: 589).

By the 1870s many physicians were abandoning the "blood-letting, blistering, leeching, cupping, sweating and purging" of the past; but most prescribed multiple drugs (Kaufman 1971: 110-113).<sup>1</sup> Physicians of the 1870s stressed that they were not dogmatic. They rejected the designation "allopathic", assigned them by homeopaths because it implied the exclusive use of medicines which produced effects opposite to the disease symptoms. Rather, they claimed to use "remedies according to reason and experience, availing themselves of all the light to be derived from physiology, pathology, chemistry, and the collateral sciences" (PMSJ 1876 XXII(1): 34). The term "allopath" also suggested that the regulars were just another medical sect.

The well-regarded physician, Dr. Gerard G. Tyrrell, stated in 1873 that he had ceased bloodletting, purging and using opiates for influenza,

using stimulants and tonics instead. In addition, patients were no longer kept in closed rooms, sweating under blankets. They were given "strong soups, albuminoids, and carbo-hydrates" instead of the "ancient regimen of water gruel, small beer, and starvation" (Tyrrell 1873: 220-221).

Dr. E. A. Kunkler of Placerville also opposed heroic measures by 1879. He felt that purgatives such as calomel and jalap were too drastic. He also opposed opium, wine, and cordials. He still used bleeding, but favored in general "cooling, relaxing, and eliminative remedies" for zymotic diseases (Kunkler 1879: 56-57). But others continued heroic remedies. For example, in 1878 an editorial remarked that diphtheria had been cured by a physician who administered 3-6 grains of calomel or more hourly "till copious dark, bilious stools occur". Bleeding was also used in this case (PMSJ 1878 XXI(2): 75). Dr. R. H. Dalton argued that year that for some unknown reason epidemic diseases had been more intense in the past, justifying the harsh remedies used by doctors then: "Fifty years ago...the practice was to treat all acute diseases by violent perturbing remedies, such as copious blood-letting, emetics, emeto-cathartics, drastic purgatives in the largest doses" (Dalton 1878: 348-349). In his current practice Dalton used such measures only in acute illnesses.

The reason physicians were becoming defensive about their therapeutic approaches was in reaction to "Conservative Medicine". This idea was already propounded by the 1860s, in part in response to earlier medical sects which favored natural cures and botanic medicines (see Part Three). The term was originated by Dr. Austin Flint and meant "conservative in the sense of conserving the body's natural powers and conservative in the

sense of abjuring harsh and unproven modes of therapy" (Rosenberg 1967: 243; Smith 1978).<sup>2</sup> In 1863 the Surgeon-General of the United States forbade the further use of calomel and tartar emetic in the army. This decision followed upon arguments, such as those of Oliver Wendell Holmes and Jacob Bigelow, against mineral remedies (Brieger 1967). But "medical nihilism", as it was called, did not significantly change the orientation of some San Francisco physicians as late as 1880. It tended to be popular among sophisticated academic physicians and younger doctors (Rosenberg 1967: 244). Medical nihilism did not challenge the generally shared equilibrium model of the body, and of health and disease.

Several influential articles on Conservative Medicine appeared in San Francisco. In 1868 Dr. E. Malcolm Morse admitted that many of the patients "cured" by "their severe antiphlogistic treatment" in fact recovered because the disease was naturally self-limited. Even more difficult was the realization that treatment had killed patients: "Whole armies of men, women, and children, in typhoid and yellow fever alone, have been hurled into their graves by blood-letting, mercury, depleting cathartics, and depriving them of proper nourishment (Morse 1868: 81). Conservative Medicine required "the avoidance of useless and injurious therapeutic measures" and circumspect application of any medicine. Improved diet was its most important feature, in Morse's view.

Several years later Dr. A. B. Nixon read a paper on this subject before the Sacramento Society for Medical Improvement. It was followed by remarks of his colleagues. Because doctors believed in artificial treatment, he said, they were unaware that "the life power of the system ...without any artificial aid, suffices in the great majority of cases" (Nixon 1873: 532--533). The virtue of medicines had been over-rated.



Eight physicians responded to Nixon's paper, but none agreed with him. Some argued that nature was merely the ally of the doctor, who must continue his ministrations. Otherwise one was practicing homeopathy. Dr. Tyrrell noted that nature could work for evil as well as good, and must sometimes be repressed. He and several others seized upon the proven value of quinine as an example. He also stressed the historic precedents of their profession: "are we to throw away the accumulated facts of ages; the wisdom of Hippocrates, the teachings of Galen, the wonderful discovery of the value of cinchona, iodine, bromine, cod liver oil; reject as untrue the thousands of cures attributed to their use, and declare they were a myth, a snare and a delusion?" (PMSJ 1873 VI(12): 583).

As the controversy between heroic and conservative medicine heated up during the 1870s, physicians became more defensive. In 1873 T. A. Snider defended bloodletting, saying that some doctors had gone too far expecting nature to cure disease, and rejecting medicines "as if all medication however skillfully employed must be opposed to nature, instead of being what it really is, auxiliary to her healing, and only opposed to her destructive tendencies" (Snider 1873: 158).

Henry Gibbons, Sr. agreed with Snider that a prejudice against bloodletting had developed. Speaking to the graduating class of the Medical College of the Pacific in 1878, he related this story:

It is rather curious that the first incident of my life on record in my memory is blood-letting. I can see myself at this moment as I lay in my mother's lap, a mere infant, aroused from sleep to behold a stream of blood flowing from my arm, and my father, who was a physician, standing by with the murderous lancet in his hand, I had hooping-cough, as my mother informed me many years afterwards, and was not more than two years old....That I survived the process is evident (Gibbons 1878b: 290).<sup>3</sup>

Gibbons argued that bloodletting had been abused, but not as widely as

its detractors alleged. People were commonly bled "once a year, on the return of spring, not because they were sick, but from the idea that they required it as a preservative or preventive". Thus the body's equilibrium was renewed and maintained as a yearly ritual.

In his hospital practice Gibbons had resumed bleeding for the pain of pulmonary and bronchial diseases, along with counter-irritation and blistering, and antimony (Gibbons 1878a: 101).<sup>4</sup> He also defended the use of mercury or calomel. It was the most commonly used medicine, even though mercury poisoning was a frequent iatrogenic effect. Gibbons remarked that calomel and antimony had been recklessly used, but primarily by quacks and people who overdosed themselves with patent medicines. He regarded the continuing popularity of these medicines as evidence of their potency. He noted that his father had used such heroic measures and had not lost a home patient in fifty years (Gibbons 1878a: 301-305).<sup>5</sup>

#### Vaccination and Quinine

The only really successful medical approaches to infectious disease during this period were vaccination against smallpox and the use of quinine to treat malaria. Vaccination kindled strong public resistance in some communities, leading to "smallpox riots" as late as 1894 among German and Polish immigrants in Milwaukee (Leavitt 1976). People feared that vaccination created and spread other diseases.<sup>6</sup> They were joined by "irregular" doctors and patent medicine manufacturers who resented compulsory vaccination as governmental interference (Kaufman 1967; Blake 1978; Rosenberg 1978b: 257). Variolation ("inoculation by rubbing crusts from active lesions into skin puncture sites") did produce smallpox in many cases. The inoculated person could spread the disease because 'humanized' virus was sometimes used. It was taken from the pustules of inoculated

humans. The skill of the vaccinator was also important to keep the skin site from becoming infected or to avoid scarring. Before calf lymph (containing cowpox) became available in 1870, the method of vaccination also spread syphilis, erysipelas and other infections. There was so much variety in type of vaccine matter and ability of vaccinators that the outcome varied greatly, and many people complained (Smillie 1952: 58; Winslow 1952: 20; Wishnow and Steinfeld 1976: 429; Leavitt 1982: 81).

I have not found evidence that people resisted vaccination in San Francisco. It was very much promoted during the smallpox epidemics of the mid-19th-century. Richard Stanwood, who lived northeast of the city, reported to his sister the problems in getting smallpox vaccination to "take" in the case of his little daughter. In April 1879 he wrote, "Bessie has been vaccinated again since I last wrote ....As usual the vaccination is not going to take". He commented in January 1880 that she had been vaccinated again, and wrote his sister of his new awareness of the controversy about it:

Bessie's 'vaccinate' is taking this time 'for surely' as she says--Did you ever read any of the arguments against vaccination? The opponents figure up an increase in consumption, scrofula, and other old diseases, besides the origin of a number of new ones, as directly attributable to it, so as to quite shake ones faith in its being the blessing to humanity we had supposed. Some distinguished physician in Germany, where vaccination was compulsory, advised his clients to fight rather than submit to it (Stanwood 1852-1884: 1/19/1880; 4/22/1879; 1/12/1880).

Less than a month later Stanwood wrote her that "Bessie's arm was so sore for a few days that we had to poultice it, but it has healed very nicely now" (Stanwood 1852-1884: 2/3/1880). This may have been an effect of the vaccination.

Mrs. Margaret Pierce wrote her sister in May 1876: "Took the children over to Doctor's yesterday afternoon & had them vaccinated - Elliott cried

very hard, Mollie only looked her reproaches" (Pierce 1869-1888: 5/1/1876). During the smallpox epidemic that year Lucy Pownall wrote from San Francisco to her mother that she had been vaccinated at the direction of her father, while they visited her aunt in the city. She commented that "My arm is quite sore but I do not mind it". She was not a child at the time, for she married three years later (Pownall 9/13/1876). Poorer people were regularly vaccinated at public dispensaries at this time.

During the 1868 epidemic an editorial berated the inefficiency of public vaccinations, saying that the whole city should have been vaccinated during the first month (California Medical Gazette Nov. 1868: 112). In 1879, over ten years later, Henry Gibbons, Sr., as President of the State Board of Health, again stressed the need for compulsory vaccination against smallpox, on the European model (Gibbons 1879a: 89). He editorialized in his own journal the next year in favor of universal vaccination. He suspected an "epidemic diathesis" would lead to an epidemic that spring (PMSJ 1880 XXII(9): 428).

Smallpox, as other diseases, was associated with immigrants. In 1869 an editorial speculated that Germans and Irish were more susceptible to the disease (PMSJ 1869 No. 28: 175). Chinatown was blamed as the source for the smallpox epidemic of 1875-76, presumably in part because the Chinese were unvaccinated. The main reason was because they were alien (Trauner 1978: 73).

The use of quinine against malaria was known to be so successful that it was used to treat a number of other diseases as well. Cinchona or Peruvian bark had been imported to Europe from Peru in the 17th-century and thence back to the Americas again (Drake 1964: xviii; Ackerknecht 1965: 98; Smith 1976: 343-347). Quinine (the active ingredient of Peru-

vian bark) kills the Plasmodium in the peripheral bloodstream, thus temporarily controlling the disease. It was not only a major drug in regular medicine, but also in a number of patent medicines, the best known being Dr. J. Sappington's Anti-Fever Pills (Findley 1968). The San Francisco medical press objected to patent medicines' usurpation of quinine. In a diatribe against "Warburg's Tincture" they argued that quinine was the only effective ingredient amidst a total of 15 (PMSJ 1880 XXIII(3): 116). On the western frontier where malaria was so common it was an accepted part of the "seasoning" process, settlers substituted dogwood bark to treat their "ague". They also used whiskey mixed with juice from green cucumber tree cones (Jones 1967: 263).

Standard doses of quinine were about one-third what is accepted today (20-30 grains daily now), but too small to be very useful. Still, quinine tends to retard the development of immunity to the disease, so receiving only small doses may have helped some people (Ackerknecht 1945: 126; Smith 1976: 354). Henry Gibbons, Sr. recalled that in his father's Delaware practice of the 1820s malarial fevers were treated with Peruvian bark. Small doses of quinine were always preceded by a mercurial purge or emetic to protect the liver and spleen (Gibbons 1878b: 292-293). Gibbons conducted his current hospital practice in the same way with malarial patients: "An active mercurial cathartic comes first in the treatment, and then a few moderately large doses of sulphate of quinia or cinchonidia" (Gibbons 1879a: 103).

There was much debate as to why quinine was effective. It was long felt to be a tonic or excitant. Thus it was believed to stimulate the debilitated body of the victim of ague. But small doses were used because malaria's fever was also regarded as an excitant. The success of frontier

physicians' large doses by the 1850s led to a general increase in effective dosages (Smith 1976: 346, 354, 366). Dr. P. B. M. Miller of Oroville, a malarial district, wrote in 1874: "I am in the habit of prescribing large doses of quinine, 15 to 20 grains being given regardless of the usual complications, until cinchonism is induced, when a rapid recovery follows" (Miller 1874: 395).

It is interesting that today malaria is increasing in other parts of the world as resistant strains develop to each of the 20th-century drugs used against it. A return to the use of quinine is occurring, in spite of its side effects. Because of this phenomenon some scientists are recommending a renewed effort to develop a vaccine against the disease (Hommel 1981).

Malaria was common in the statistics of disease in San Francisco. It was reported as well in the letters and diaries of local people. John T. Mason, a rancher in Colusa County, frequently noted in his terse daily journal that he was sick, noting one day: "Went below after cattle had ague took pills" (Kingsley 1859-1902: 9/4/1871). The pills were undoubtedly quinine. Elizabeth Powell heard in 1869 from a governess friend in San Francisco: "poor child! my heart does ache for her; she has chills again and it is so forlorn to be sick, poor and homeless" (Powell 1854-1915: 2/13/1869). Joseph B. Pownall priced quinine in San Francisco in 1879 for his parents in Tuolumne County. He found it cost between \$4.00 and \$4.50 an ounce. His mother wrote him that a friend had to return home because "he was sick with chills". As late as 1895 Pownall was receiving quinine and other drugs from his mother, then in San Francisco. But he noted that he had "not had any use for them so far" (Pownall 12/13/1876, 10/5/1879, 5/2/1895).

Mary Hallock Foote sympathised with her close friend, Helena, in 1875:

My dearest girl - It makes me very sad to think of you ill - with 'knives in the back of your head' and - (almost worse than the suffering) - that peculiar feeling of hopelessness which is one feature of malaria - I do hope you will take quinine - in small doses - one or two grain pills every six hours and a tonic. I must have been, last spring, very much as you are now. The Doctor said I must stop work and go away from home and all that - but I was cured instantly by that blessed quinine!" (Foote 1868-1915: 1/1/1875).

Richard G. Stanwood reported that several friends were "laid up with chills & fever" in 1878, although one case turned out to be only earache. In 1879 he wrote his sister that "Miss Pierce came up yesterday from Oakland where she has been sick some nine or ten weeks with chills and fever. She hadn't been well here, but her illness didnt assume that form till after she had been there a little time" (Stanwood 1852-1884: 7/30/1879, 9/19/1878).

#### Healing Institutions: Hospitals, Dispensaries, Charities

Early in the 19th-century those suffering from infectious diseases were treated at "fever hospitals" or "pest houses". Later in the century such hospitals retained this function on the grounds of larger general hospitals. Poor people, who were the usual patients, often hid from the authorities in order to avoid going to a pest house. They knew they were quite likely to die there. Removal also separated them from their families and made eviction from their houses or loss of their jobs possible. It was known that "patients were peremptorily managed by underpaid, frightened and callous nurses. Such hospitals found it difficult to attract and hold staff and Sairey Gamp types persisted in fever hospitals" (Lotchin 1979: 185; Smith 1979: 243).<sup>7</sup>

Regular hospitals were so overcrowded that examinations took place in public places. Treatment was often actually conducted by students. Patients were expected to be docile and deferential. No attention was given to the patient's living conditions or personal history (Smith 1979: 264). Even today with new emphasis on treating "the whole person," doctors rarely want to listen to such accounts and often do not see their bearing on disease or therapy.

In San Francisco these conditions were typical. During the 1868 smallpox epidemic victims were required to go to the smallpox hospital. The City Health Officer at the time stated that he did not expect people who could be treated at home (i.e., the upper classes) to comply. Public outcry during this epidemic brought attention to conditions in San Francisco hospitals (California Medical Gazette 1868 I: 37-40; Read and Mathes 1958: 45).<sup>8</sup> An editorial in the medical press said "There is no reason why San Francisco should not have a hospital that would be comfortable for patients, and at least not a reproach and disgrace to the size and wealth of the city" (California Medical Gazette 1869 I: 133). Henry Gibbons, Sr. pronounced the City and County Hospital still disgracefully overcrowded and improperly ventilated in 1871 (State Board of Health, First Biennial Report....1870 and 1871: 30-32).

A pest house had existed in San Francisco with every epidemic, beginning with a shanty during the 1850 cholera epidemic. The pest house was moved to Rancho San Miguel five miles from the city during the 1861-62 smallpox epidemic. In 1868 provision was made for a pest house associated with the new City and County Hospital building on its current site on Potrero Avenue (Read and Mathes 1958: 47-48).<sup>9</sup>

In his recollections of 18 years of practice in San Francisco,



Henry Gibbons, Sr. said that the hospital patients he had observed at the City and County Hospital for 12 years and St. Mary's Hospital for 6 years came "largely from the ranks of the poor and destitute". He felt that such patients preferred being in the hospital to the hardships of being sick at home without help. He said that most of the patients were men and most had consumption. The majority of patients were Irish, as seen in Chapter Five (Gibbons 1879a).

There were a number of other hospitals in the city established for special groups such as women and children, and ethnic immigrants. In 1875 twelve hospitals were listed in a city guide: the Almshouse, the California Women's Hospital, the City and County Hospital, the Italian and Swiss Hospital, the French Hospital, the German Hospital, the Small-pox Hospital, the San Francisco Female Hospital, the Foundling Asylum, the Lying-In Asylum, St. Mary's Hospital and the U. S. Marine Hospital (The Strangers' Guide....1875: 33; see also Langley 1874: 56-58; 1875: 46-49; 1876: 41-44; Lloyd 1876: 431-435; Harris 1932: 102-116).

Some of these hospitals came in for occasional criticism in the medical press. For example, the Western Lancet charged in 1873 that the San Francisco Lying-In Hospital and Foundling Asylum was malarious, over-crowded, and under-staffed. But the Secretary and Attending Physician and Surgeon disputed each of these criticisms. He said that the mortality among children was the result of lack of natural food (i.e., breast milk), a problem common at other hospitals as well (PMSJ 1873 VII(5): 241-242).

Immigrant hospitals were supported by ethnic benevolent societies. For example, in 1871 36 such societies were listed in a city guide: 16 of them were Jewish; 3 were Irish; 2 "colored"; and others represented Chinese, Austrians, British, Germans, Greeks, Russians, Slavonians, Italians,

French, Mexicans, Portuguese, Swiss, and Scandinavians. There were also societies for other special groups such as religious groups, orphans, mechanics, clerks, women, veterans, and deaf and dumb. There were 63 Protective Societies listed that year, mostly based on occupation, and probably functioning as banks and insurance companies. By the end of the decade there were 103 benevolent societies listed, now including Russian and Swedish (Langly 1871, 1878; *The Stranger's Guide...*1875; Stern 1973). The French and German hospitals supported by benevolent societies survive to this day, as do St. Lukes and St. Mary's, originally staffed by Irish Sisters of Mercy. Other groups during the 1870s included the West Indian Benevolent Society and the Six Chinese Companies. All these groups were set up to provide aid during illness and after death (Averbach 1973; Parker and Abajian 1974: 13; Trauner 1978: 70-87; on the rebuilt German Hospital see PMSJ 1878 XX(10): 476-477). As will be discussed later, Chinese patients were treated in their own community, but did not have a hospital of their own until 1899 (Trauner 1978).

In 1876 B. E. Lloyd praised the charities of San Francisco highly. He said that "the benefits they bestow are proved by the marked absence of cases of extreme poverty and suffering, from the community....so that to-day there should not be a single worthy person suffering from lack of attention, or the necessaries of life" (Lloyd 1876: 429-431). In the discussion to follow on medical dispensaries, we shall see that the key word here is "worthy".

Those poor who were not treated by private doctors or in hospitals also had the option of attending one of the clinics or dispensaries conducted by the city's medical schools. Before the 1870s clinics were run "in a completely incidental and haphazard manner as the need arose or in

accordance with the whims of individuals". The City Hospital provided prescriptions to 1,000 outside patients a month. The City Health Office provided medicines to the ill, and some private physicians developed free clinics. In addition most of the other hospitals and benevolent organizations provided free care (Read and Mathes 1958: 66).

Charles Rosenberg (1974) reports that dispensaries in eastern cities at this time usually had a resident physician and an apothecary as well as a consulting staff from city medical establishments. They were privately endowed and usually had little money. In San Francisco the medical school dispensaries were open three or four days a week. The city supplied medicine and the physicians worked for free (PMSJ 1873 VII(9): 475). By the time of the financial depression of the late 1870s the city no longer contributed to these clinics. About 300-400 private physicians then provided approximately \$100 a month each in free services (Read and Mathes 1958: 80).

The primary function of dispensaries was to vaccinate and to provide prescriptions. They treated the "worthy" poor initially, those who did not end up in public institutions. As immigration increased the clientele became increasingly foreign and more and more destitute. Rosenberg notes that the almost exclusive drug therapy conducted by dispensaries contrasted therapeutics in private practice. The middle class patient received more attentive treatment and appropriate regimen adjustments; but "The city poor could not well vary their diet, take up horse-back riding, visit the seaside, or voyage to the West Indies" (Rosenberg 1974: 36). Private physicians in San Francisco often suggested such approaches to their patients (see Chapter Fourteen).

The establishment of dispensaries was motivated in several ways.

It was a humanitarian and Christian responsibility to care for the less fortunate. Caring for them was also a means of protecting higher classes from contagion. Most important however, was the function of dispensaries as teaching hospitals, providing clinical training and the prestige associated with that background (Rosenberg 1974: 38-41). The two medical schools in San Francisco established dispensaries because neither had hospital affiliations when they began.

In the early years physicians could control the type of patient seen in dispensaries; i.e., the "worthy poor". These honest poor could thus be kept from poorhouses and public hospitals. By the 1850s on the East Coast and the 1870s in San Francisco the clientele for dispensaries changed with the massive influx of foreign immigrants. They no longer appeared to be "deserving poor" to dispensary physicians. Physicians found themselves faced with people who spoke foreign languages, followed different customs, and resisted treatment.<sup>10</sup>

Many who worked in dispensaries became aware that the drugs they were dispensing were not the answer to the health problems of their patients. Fundamental changes were needed in living conditions of urban immigrants. Physicians could not escape their 19th-century context however, and interpreted these problems in moral terms. Nor could they hide their feelings of distaste and contempt for the truly alien, destitute and diseased people they served (Griscom 1970, orig. pub. 1845; Smith 1973, orig. pub. 1911; Brieger 1977, 1978). Moral judgments about the origin of disease led to fatal criticisms of the dispensary system. It was regarded as an unnecessary charity, no longer aiding the deserving poor, but the unworthy. Rosenberg (1974) concludes that the fall of the dispensary system in the 20th-century reflected changed perceptions of social needs and

the medical profession's perceptions of its own purview and responsibility.

### Summary Chapter Eight

There was little reason in the 19th-century for physicians to analytically associate their etiological beliefs and their therapeutic practice. Practice was based on a commonly accepted equilibrium model of the human body. Regular physicians, alternative practitioners and the general public alike regarded disease as a disruption of the body's natural balance that might arise from either internal or external causes.

The justification for harsh "heroic" medicines such as mercury and practices such as bloodletting was evident. People could observe immediate physiological responses that were believed to counteract the disturbance of disease. Physicians did not have diagnostic tools other than their basic senses, so the focus was on observable bodily changes. Drugs were used that produced such changes. Therapeutic procedures addressed a shared cultural definition of illness, so whether or not disease was affected, such treatment was reinforced.

In time the social definition of effective therapeutics began to change, although the equilibrium model of the body remained undisturbed. Conservative medicine and other alternative approaches began to stress milder treatments with more attention to preventive and hygienic measures. San Francisco physicians remained adamantly in favor of the older, heroic approaches until well past the 1870s. Their only really effective efforts were vaccination against smallpox and the use of quinine in treatment of malaria. In spite of physicians' identification with science, both of these successful measures had been discovered by chance, not experimentation.

The regular profession involved themselves in therapeutics that

took place in hospitals, dispensaries and other institutions which treated the poor and immigrant classes. But they could not control the tendency for people of all classes to doctor themselves or to use alternative practitioners. Because of this competition, physicians allied themselves with traditional, time-tested therapeutics and ridiculed other members of their profession and other healers who believed in allowing nature to take its course. But patients tended to choose methods that seemed effective and least unpleasant, at least until regular physicians could depend on the cultural authority of science towards the end of the century.

Until then there was little security in the medical profession. It is not surprising that the miasmatic, anti-contagionist, anti-germ-theory, pro-heroic medicine ideology epitomized by Dr. Henry Gibbons, Sr., was strongly defended in the face of changes and challenges on all sides. Tension in the regular medical profession interacted with and was responsive to a high level of social change. The city was rapidly experiencing 19th-century growth, urbanization and industrialization. Accompanying economic stress affected the health of a great in-migration of unemployed newcomers. They could not rely on only the regular profession for their health needs, especially since their class tended to be shunted to dispensaries and public institutions for largely custodial care.

#### Endnotes Chapter Eight

<sup>1</sup>Doris Muscatine (1975) has noted that "the pioneer Anchor Drug Company in North Beach stocked leeches until the late 1950's, and the nearby Lovotti-Rossi Pharmacy was still selling them in 1974 at \$2.50 each" (Muscatine 1975: 238).

<sup>2</sup>Flint said, "The conservative physician shrinks from employing potential remedies whenever there are good grounds for believing that diseases will pursue a favorable course without active interference. He resorts to therapeutical measures which must be hurtful if not useful only when they are clearly indicated". Flint did not entirely reject heroic approaches (Flint 1972: 134-142, orig. pub. 1862). Jacob Bigelow had discussed "self-limited" diseases as early as 1835 in a classic oration. He identified "certain morbid processes in the human body [that] have a definite and necessary career from which they are not to be diverted by any known agents with which it is in our power to oppose them". He argued that most people, at least unconsciously, recognized such diseases. He cited whooping cough, measles, smallpox and scarlet fever among them. Such diseases did respond to the palliative measures of physicians, but were "controlled by nature alone" and could not be cured (Bigelow 1972: 98-106, orig. pub. 1836).

<sup>3</sup>John Haller provides a good description of the uses and justification for bloodletting. He says, "The relief given to the constitution by perspiration, to headache by epistaxis, to the congested uterus by menstrual flow, or dyspnea by slight haemoptysis, fathered notions that the loss of blood from artificial wounds would prevent or even cure disease". (Epistaxis is bleeding from the nose; dyspnea is labored breathing and haemoptysis is coughing up blood). General bloodletting involved phlebotomy (venesection) or arteriotomy. Local bloodletting used leeches, scarification or cups from capillaries near the diseased area. It was believed to reduce the body's heat in cases of fever (Haller 1981: 36-63).

<sup>4</sup>Henry Gibbons, Sr. might well be compared to Dr. Benjamin Rush working in Philadelphia almost a century earlier. Both were staunch believers in the miasmatic theory of disease and tragic advocates of bloodletting. They are both examples of how sincere and dedicated doctors and forceful personalities could be quite wrong in their etiological and therapeutic beliefs (see Powell 1949). Gibbons trained in Philadelphia; so traditions in professional life are passed on.

<sup>5</sup>Tartar emetic, composed of antimony and potassium tartrate, was a major element of 18th- and 19th-century materia medica. It was used as a diaphoretic (producing perspiration), emetic (producing vomiting), expectorant, sedative, cathartic (strong laxative), and irritant. It was administered as a pill or powder mixed in syrup or gruel, as an ointment or plaster. It was also a major ingredient in many well-known patent medicines, such as Ayer's Cherry Pectoral and Jayne's Expectorant. Calomel was mercurous chloride, a "bilious purgative", used widely for all diseases. It produced salivation, mouth ulcers, sloughing of the gums and necrosis of the lower jaw. But it was also believed to cure diseases, especially biliousness and fevers (Haller 1981: 67-89). The iatrogenic effects of heroic measures are discussed in Coulter (1973: 63-73). Courtwright (1982) traces the history of opiate addiction which followed in part from its use in professional and popular remedies.

<sup>6</sup>Complaints about the dangers of vaccination continue today. The DPT (diphtheria, whooping cough, and tetanus) vaccine has caused brain damage and death; and it is believed to be fairly ineffective in preventing the three diseases (Whole Life Times April/May 1983: 44).



<sup>7</sup>Powell's (1949) description of a Philadelphia yellow fever hospital is an especially effective one.

<sup>8</sup>For the pest house rules of the time, including the provision that no private nurses were allowed, see California Medical Gazette July 1868: 28.

<sup>9</sup>For earlier history of hospitals in San Francisco, see Harris (1932: 108-116); Read and Mathes (1958: 54-55); Muscatine (1975: 242); Lotchin (1979: 184-187).

<sup>10</sup>Such cultural conflicts were the foci of early medical anthropology work as anthropologists attempted to mediate between indigenous people and the newly established Western medical practitioners attempting to treat them.

## PART THREE: POPULAR AND SECTARIAN ALTERNATIVES

## CHAPTER NINE: POPULAR ETIOLOGICAL BELIEFS

Most of the people suffering repeated epidemics in puritanical 18th-century America attributed them to the divine justice of God's wrath. This belief survives as part of the health world view of Americans today, either explicitly or implicitly in the "Why me?" syndrome most people experience on becoming ill. It is common cross-culturally to divide illnesses into those naturally or supernaturally caused. People select types of therapy based on this etiological distinction. A native practitioner or shaman is usually chosen for supernaturally caused illness. The immediate explanation of an illness may also be distinguished from its ultimate cause. Thus an ultimate supernatural causation may act through a more mundane earthly cause. This operation is sometimes thought of as the "why" and "how" of disease. It is not unusual to find germs as an immediate etiological explanation (how) associated with witchcraft or some other supernatural cause (why). Cross-cultural etiological explanations share with early 19th-century Western medicine a recognition of multi-causality in this way (Polgar 1962, citing Clark 1959; Colson 1971: 227; Seijas 1973: 545; Snow 1974: 83-84; Foster 1976).

God's wrath and direct contagion could both be responsible for disease. They accounted for both ultimate explanation and immediate etiological cause. People in the 19th-century were able to accept "the broad relationships" in disease contagion. But physicians hesitated to believe in it because they could not figure out scientifically the mode of transmission. Sin was believed to be the ultimate cause of the cholera epidemic of 1832 in America, with contagion as the instrumental cause (Winslow

1952: 45; Rosenberg 1962: 43-44).

When cholera returned in 1849 however, the poor, who were its chief victims, understandably began to reject the divine justice explanation. Middle and upper class people continued to regard the causes of cholera as a moral issue. They held immigrants and the poor responsible for living conditions that spread contagion. It was believed that only the poor died from resulting diseases. Evidence supported this point of view. For example, more than 40 per cent of the "dying" in New York that year were Irish-born. In 1866 even public health reformers persisted in believing in predisposing immorality and sloth. The issue had subtly changed from a religious vs scientific controversy into class conflict (Rosenberg 1962).<sup>1</sup>

Prior to the 1870s domestic health manuals taught people that they had some control over the presence of health or disease in their lives. Good health was believed to originate in the balance of internal systems of the body. If this equilibrium was maintained by attention to hygienic rules, sickness was avoided. Attention to diet, cleanliness, rest and bowel regularity was emphasized. The natural corollary to this viewpoint was that disease resulted from transgression of these natural "laws" of the body. Disobedience to hygiene practices was equivalent to sin and "would certainly bring down wrath in the form of bad health". Judgment might not come from God, but it did come from Nature, a suitably supernatural authority to motivate people to curb excessive behavior. Disease was the punishment for immoderation (Fellman and Fellman 1981: 28, 33-35, 43-45).

People were advised not to blame disease on Providence, when in fact disregard for hygienic matters was responsible. The Family Health

Annual published in Oakland, California blamed parents in 1878 for ignoring the source of infant deaths in "unwholesome food, as milk from diseased and poorly fed animals, impure air, and lack of careful nursing". Parents were negligent in attributing disease to an act of God (The Family Health Annual 1878: 17).

The ultimate attribution of illness to some form of wrongdoing is common cross-culturally. Illness is regarded as a sanction and etiology becomes "a stringent guide to social expectations" (Lieban 1973: 1049). That epidemics were blamed on living conditions of new immigrants in 19th-century America is a commentary on the society's inability to cope with an overwhelming number of unassimilated poor. The victim was blamed. The immoral way of life of these people was regarded as responsible for the disturbance of natural equilibrium that was causing disease. Until conformity to social expectations was achieved by these newcomers their behavior would be regarded as immoral and their illnesses as supernaturally sanctioned.

Thus the increasing heterogeneity of society and urban life, increasing competition for jobs, and a general sense of deteriorating social life resulted in people beginning to blame others, not themselves, for transgressing natural health laws. Inner mental and physical control became more and more necessary in the face of this outer chaos. But illness was now seen as more than a personal responsibility. External conditions could create it; and others' lack of personal control could be blamed. The newcomers were diseased and lived in squalor and social corruption. They transgressed natural law and spread their transgressions and punishment through contagion. While physicians found germ theory difficult to accept, people in general found that it suited admirably

their changing perceptions. People could now blame germs for disease and their spread on the same folks who were creating social disruption in general (Rosenberg 1976: 8-13; Fellman and Fellman 1981: 10-15, 38, 49-50).

"Then My Poor Baby Took It": Beliefs about Contagion

Belief in contagion of infectious diseases was common at the popular level in the 19th-century. Professional physicians were often scornful of this belief. But patent medicine manufacturers were more attuned to popular views. For example, William Radam patented his pink liquid "Microbe Killer" in 1886. This medicine killed all germs. His etiological explanation was a convenient amalgam of miasmatic and germ theories (Young 1961: 151).

In letters and diaries we find evidence of people's belief in contagion. For example, Mrs. Joseph Newmark often mentioned in her autobiography her beliefs about the etiology of the various diseases she and her family experienced. She said that when diphtheria was epidemic in Sacramento her sister went to help a neighbor whose child had it: "Unfortunately she brought the illness with her. Her little daughter became very ill with it and both children died in the same week....I...went in and saw the dear child for the last time. Then I also took diphtheria and was very ill" (Newmark 1900: 6). Mrs. Newmark clearly believed in the contagiousness of infectious diseases. When all three of her children had whooping cough in the 1870s she observed, "one caught it from the other and then my poor baby took it" (Newmark 1900: 9). Later her brother died after an operation for hemorrhoids in San Francisco. It was complicated by blood poisoning, and "the end of the sad illness had been diphtheria". When she returned to Sacramento after seeing him, she took off

all her clothes to air them in the yard because,

contagion for the children, bad. I did not go near the children until I had changed, but, strange to say, one after the other of the children took diphtheria and even my Joe was not immune. What fear and fright I suffered! The strangest thing was that this disease was not present in Sacramento at this time and that, in spite of all my precautions, I had brought it in my clothes (Newmark 1900: 10).

In the 1880s her son again came down with diphtheria. This time Mrs.

Newmark expressed a miasmatic etiological idea. She said,

One day my dear Milton was coming home from school and the ground was dug up. He had left home quite well and when he returned at noon, he complained of headache and had to lie down; he had a high fever ....it was diphtheria. This was caused by the exhalations from underground, where my dear son had passed....When I expressed my fear to my dear Millie that she might become infected, she would not listen; God had protected her (Newmark 1900: 14).

The doctor she called in may have provided Mrs. Newmark with the miasmatic explanation. She continued to fear contagion from the disease. She also expressed belief in ultimate causation by calling on God's protection.

The artist Mary Hallock Foote wrote her friend about fear of contagion in 1868:

My sister Bessie has been ill for a long time of scarlet fever--so very ill, that for a few days we had almost forgotten that there was a world outside of her sickroom. Then came the anxiety lest the trouble should spread, and the members of the family who had been exposed fall victims to the disease. We spent two weary weeks of suspense, until at last when no new cases appeared and the Dr. said that all further precautions were unnecessary, we could breathe freely (Foote 1868-1915: 9/16/1868).

Mrs. Margaret Pierce expressed a similar fear in 1881 when her two children had scarlet fever. Friends and her aunt had not visited because they feared getting the disease themselves or transmitting it to other children. Another friend came to see her, "but I sent her - and the baby, right off home, I was so scared" (Pierce 1869-1888: 12/14/1881).

### Temperaments, Humors, Heat and Cold

Some general health beliefs were shared by people in general and their physicians in the 19th-century. The rather fatalistic idea of inherited temperaments or constitutions was one such idea. As beliefs in divine punishment for wrongdoing became more secularized, they were replaced by notions of the inheritance of acquired characteristics. Thus any excessive behavior might be passed to unborn children. This inherited constitution possessed an accompanying disease susceptibility. Thus immorality continued to receive appropriate retribution in the form of disease (Rosenberg 1976: 10-11, 25-53).

This idea of inherited constitutions originated as part of the theory of humoralism of ancient Greek theorists. The Constitutional Typology of the 19th-century included the sanguine, bilious or choleric, melancholic, phlegmatic, and nervous constitutions, in various versions. Sanguine types were healthy but had a predisposition to heart and artery diseases. They were morally weak and susceptible to venereal diseases and insanity. The bilious had over-active livers. They were likely to get hepatic diseases, indigestion and depression. The lymphatic types tended to be obese and to have gout, rheumatism, apoplexy, cholera, cancer, tuberculosis, and other infections. The nervous types were most susceptible to illness, such as emotional illnesses, liver problems, indigestion, neuralgia, epilepsy and insomnia (Haller 1981: 3, 18-21).

These beliefs were held by medical professionals and lay people. Life insurance companies asked a person's temperament on their application forms. Physicians diagnosed and prescribed on this basis. As medicine became more sophisticated, physicians began to use the term diathesis to indicate susceptibility to a certain disease, and temperament to sug-

gest the whole physiology of the person.

Clearly the predominance of such ideas lent itself to social constructions of disease. Attitudes towards people of certain racial and national backgrounds derived naturally from the notion of inherited constitutions and susceptibilities, and contributed to developing social attitudes about urban immigrants (Haller 1981: 3, 16-18). When the Pacific Medical and Surgical Journal printed articles associating certain ethnic groups with certain diseases it was expressing the common conception of inherited predispositions. Thus Germans might be more likely to get smallpox, and the Chinese to have leprosy. The Irish succumbed to tuberculosis at least in part because of their tendency to drink, and because of the transition from a farming to an urban form of life (Gibbons 1879b, c; PMSJ 1871 No. 45: 423; PMSJ 1878 XXI(4): 179-180; PMSJ 1879 XXII(1): 33).

As physicians and others became more reluctant to attribute illness directly to divine retribution, the idea of inherited disease susceptibilities took its place as a justification for social sanctions. The clearest demonstration of this in San Francisco was the periodic attacks made on Chinatown by the Health Officer, J. L. Meares, in the 1870s. Heredity of disease predisposition was not regarded as completely deterministic. Efforts could be made both individually and on a societal level to overcome this destiny. Thus both personal hygiene and moral behavior and public health and sanitation efforts were needed (Rosenberg 1976: 25-53). With the beginning of the 20th-century these ideas had coalesced into racist and eugenicist forms, especially directed at the "new" immigrants from southern Europe and at Blacks.

Today beliefs in temperament and constitution have been attenuated



to epidemiological associations between sex, age, and strength, weakness and susceptibility to disease. Popular social constructions of disease etiology may still include heredity and familial susceptibilities along with beliefs in infection, environmental and psychological causation. The diseases attributed to these causes often overlap (multifactorial causation) and may not correspond to biomedical classifications. For example, women interviewed in Scotland recently regarded some infectious diseases as subject to heredity or inherent susceptibilities or as resulting from environmental exposures and poverty. The very ancient belief in bodily humors still exists in some American communities today and was certainly part of the folk health beliefs of the 19th-century. The four humors: blood, phlegm, black and yellow bile, each arose from certain parts of the body and were related to heat and cold, wetness and dryness (Snow 1974: 88-89; Foster 1979; Blaxter 1983).

The hot/cold theory of disease has been common through history and around the world. Recent research in Great Britain reveals such beliefs still among the older population. Hot and cold conditions are further broken down into wet and dry. Chills and cold are produced environmentally; but the heat of fevers is attributed to contagion, to germs, and thus to social relationships (Helman 1978). Similar beliefs were present in both professional and popular 19th-century disease ideologies. They were based, as are many medical beliefs, on a theory of opposites. Much of heroic therapy reflected ideas of opposition, a notion homeopathy directly contradicted. The heroic approach of bleeding a feverish patient derived from the idea that this would relieve over-heated blood (Foster 1979). In 1878 and 1879 the San Francisco medical press reported that cold water treatments for fevers were unsuccessful. In Germany this therapy had been

used for typhoid fever:

Fever being heat, and the temperature of the blood being elevated several degrees, physiological medicine dictated external cold, and quinia internally, as the proper apyretics. But the cold water has already run out, and the German physicians, who were loudest in its praise, have ceased to rely on it (PMSJ 1878 XXI(1): 32; see also 1879 XXII(6): 287-288).

Water therapy was a popular sectarian approach to disease treatment as well.

In popular ideology the hot/cold theory states that the normally warm body is made vulnerable to attacks of cold. Thus susceptibility occurs especially after eating, bathing, exercising, sleeping and during menstruation, all of which warm the body. Some of the folk remedies to be discussed in this chapter reflect these beliefs. For example, barley water cools the blood and mustard plasters extract cold from the chest (Helman 1978; Foster 1979). Europeans who migrated to the United States may have had good reasons for their belief in hot/cold theory. Liniments and other temporary applications of heat briefly warmed people who lived in cold countries in inadequately heated or unheated dwellings (Smith 1979: 303, 339). Hot/cold theory remains quite common in Latin America today (Snow 1974: 89-92; Foster 1979).

A final very important popular health belief was again shared by 19th-century physicians (Chapter Eight). It was the idea of avoiding disequilibrium or imbalance or any expression of extremes. This idea was propounded in popular home health manuals. For example, intemperance, eating too much, dancing too much, sleeping too late, exercising too little, might all lead to disease (Jones 1967: 259). Similar ideas exist in America today, and also form a large part of new wholistic health approaches. Excess of various kinds weakens the body and makes it susceptible to dis-

ease sooner or later (Snow 1974: 87). Those who catered to popular health beliefs, the purveyors of patent medicines, made imbalances central to their sales pitches.

#### Popular Health Beliefs in San Francisco

In her amusing account of life in San Francisco in the 1870s, Harriet Lane Levy explained her mother's attitudes towards good health:

Illness was a misdemeanor, a stigma to be defended as we screened a false tooth. To a few temporary disorders Mother raised the bar; a sore throat, a headache, an upset stomach, even mumps we might divulge without diminution of matrimonial asset; but the ear listened stethoscopically to the protracted cough -- consumption! And anemia, like an unsanctioned pregnancy, was whisked away to a country farm....A man wanted a sound wife, Mother said, and it was well that health should announce itself in a high color and a full figure (Levy 1975: 72, orig. pub. 1937).

Harriet's suitors were inspected by both her parents for "health and the outward signs of vigor. If Mother murmured 'Blaas (pale)' under her breath...he was practically done for" (Levy 1975: 218, orig. pub. 1937).

Even today the features that people in general use to define diseases are seldom those chosen by scientists and physicians (unless people adopt professional nosologies). The "consequences and preconditions of illnesses" are stressed rather than definitions of etiological and physiological features. People are concerned with the why and how of illness and with its implications - its level of seriousness or curability. Then these categories are subdivided into considerations of inheritability, age-relatedness, and psychological effects (D'Andrade 1976: 159). In another formulation, most illness episodes are interpreted by the sick through pragmatic "everyday thinking" about implications for one's life. Scientists and physicians engage in "systematizing thinking" by which

they bring the episode into coherence with their premises and assumptions (Young 1976: 9-10). To really understand the impact of diseases on people their own cultural expressions about it must be examined (D'Andrade 1976: 179). For the 1870s this interpretive approach is best achieved by looking at letters and diaries.

Examination of contemporary San Francisco manuscripts yields examples of health beliefs mentioned. For instance, Mrs. Margaret Cameron Pierce was a believer in the hot/cold theory. She suffered all her life from a malady which was never properly diagnosed. She had chronic sore throats and heart pains and palpitations. As a young woman in 1868 she once treated her headache and drenching in the rain with a warm foot-bath, a cold head-bath and going to bed (Pierce 1868: 3/13). Later as an adult she attributed her illness to the reaction of her thin blood to cold weather. She also remarked that a relative "got cold" getting up at night with a sick child and became ill herself as the result. Mrs. Pierce worried that her husband would be sick with diarrhea because of hot weather (Pierce 1869-1888: 11/22/1874; 6/16/1876; 11/8/1876; 3/18/1877). Mrs. Joseph Newmark attributed her children's measles to living in an unhealthy house in which there was a "great draught". She recognized however, that it was unusual for the children not to have acquired immunity, since they had had the disease before (Newmark 1900: 13).

Beliefs in bodily equilibrium and the necessity of moderation to maintain health are found among San Franciscans of this period. Immoderation, in the form of overwork, excessive mental or emotional stress, overeating and sexual overindulgence inevitably led to disease. Even the unnatural rhythms of city life, with artificial lighting at night, might encourage immoderate habits (Fellman and Fellman 1981: 31-33, 43-45).

The idea that extremes are deleterious to health reflected an awareness that social change was producing stress. Competition in business and the freedom of choice of American life produced ambiguity and anxiety, which in turn encouraged behavioral extremes. The morally wholesome position was one of moderation in all things, including class level.

A local physician produced a book in 1867 that discussed in detail thirteen causes of debility that predisposed people to disease. These causes were imperfect nourishment, impure air, excessive exertion of body and mind, want of sleep, want of exercise, long-continued heat, long-continued cold, spirit drinking and habitual intoxication, depression or grief, excessive emotion, defective cleanliness, defective ventilation, and diseased or improper food. He also discussed the seriously defective drainage and sewage removal in San Francisco. He remarked that resulting diseases were not class-specific:

In San Francisco the lodging-houses are crowded, and I am frequently nearly stifled on entering one where there are a number sleeping together, and unless great supervision takes place in some of these places, fever (where least expected) will break out in its worst form - namely, of a low, typhoid character; and that, with the horrible condition of the drainage of the city, and the amount of decomposing animal and vegetable matter, will bring a devastating plague, not confined only to our poorer classes, but reaching those parties who imagine that by living in the suburbs they will escape the infection, and therefore interest themselves but little in this question. They must not, however, forget that they come into town to business, and that they may be stricken perhaps at their counting houses, or the contagion may seize upon their clothes, and they can take it into the bosoms of their families, and thus strike down the little ones who come clinging to them to give the welcome-home kiss. Every one is interested in this question, high and low, rich and poor (Hall 1867: 77-78).

The disease-producing nature of urban life affected all. But it clearly originated in the unregulated life of the poor, from whence it spread to the innocent.

A number of my informants commented on imbalances and excesses leading to disease. On several occasions Mrs. Pierce attributed illness to excessive activity. In 1869 she wrote that her husband, "James has not been well for a week or more; in the fall there is always a rush of warehouse business, and he works very hard indeed, and then the heat and work combined, and a bad state of the system brought on a bilious attack so that he was quite miserable for a while" (Pierce 1869-1888: 10/10/1869). A few years later she retreated for a rest to the country because she was "quite run down" by her musical activities and caring for a young baby. This excess of activity caused her old complaints and a loss of appetite and paleness (Pierce 1869-1888: 7/22/1873).

Mrs. Newmark also suffered from over-work. Taking care of her sick daughter and also working in the family store once caused her to become very ill with a bad cough, so that she had to retreat to the country. Some years later she became ill because she was assisting their single servant with the laundry. This break-down in her health led eventually to surgery (Newmark 1900: 12).

Such problems did not happen only to women. Young Edward Robbins Howe, like so many other men of the 1870s, had trouble finding permanent, satisfactory employment. He suffered from frequent dyspepsia, biliousness, headaches, catarrh, and diarrhea. He wrote his father in 1871:

You may be surprised to hear that I am about to make another change. I find that working 12 hours at night has been gradually using me up, and that I cannot stand it any longer. It is impossible to make up in the day time that I have lost in sleep at night, and my habits of life have been turned so topsy-turvy that I have dyspepsia awfully & feel utterly wretched the greater portion of the time. Without health life is not worth having, so I have determined to quit this work at the end of the month, and seek a more healthy employment (Howe 1869-1874: 11/21/71).

Howe expressed other ideas about health in his diaries. He was quite impressed by the sudden death of one of his employers and the reaction of the widow. He wrote his father:

I have had a very striking example of the folly of giving oneself up entirely to a single thought & purpose...he worked like two men all day long...worked at figures or correspondence all the evening, & would often be up half the night with his sick wife. This constant strain was too much for any man to stand long, and as soon as the body was taken sick his mind gave way under the pressure, and the malady soon found his weakest organ--the heart (diseased by inheritance)--and that soon ended him (Howe 1869-1874: 6/23/1872).

This extract illustrates how inherited susceptibility could be brought out by excessive activity. One's natural constitution could also dictate survival. Howe commented that in spite of the poor health and grief of the widow, "I believe she may eventually recover entirely, for she has naturally a very strong constitution" (Howe 1869-1874: 5/6/1872).

Having various of one's systems out of order could lead to illness. Howe commented in 1869 that he suffered a great deal after having a wisdom tooth pulled, in part because "my blood was generally out of order" (Howe 1869-1874: 12/22/1869). Mrs. Amelia Stein commented in 1884 that her daughter Gertrude's system was out of order according to the family doctor. He gave her medicine for a pain in her arm (Stein 1878-1884: 4/4/1884). Apparently the San Francisco way of life led to many irregularities and imbalances. As early as 1866 a woman who had lived there a year commented that "sudden deaths are very noticeable here, particularly among gentlemen, not from infirmity of years, but from high living I suppose, as they have the name of being great epicures" (Ingalls 1865-1866: letter 21, p. 2). Could such excesses affect the good life in the Bay Area of the 1980s? Auto-immune deficiency disease and herpes virus have both received much attention recently as diseases attributed to sexual

excess and immorality.

Regularity in one's life and care with one's diet were valued. Mrs. Pierce commented on these issues frequently. She watched her own diet and that of her children, and she wrote her sister that she should eat more and take less medicine. She recommended that an older woman who was not strong "eat good rare steak and a glass of port every day, if she will". And she attributed the good health of her aunt to "her careful diet, and regular habits of life" (Pierce 1869-1888: 1/5/1874; 11/12/1874; 3/9/1875; 11/8/1876; 3/18/1877).

#### Climate and Seasoning

The concern that professional medical men had for conditions of the climate and atmosphere was found also at the popular level. For example, the popular 19th-century theory of acclimation proposed that long residence in a place provided immunity to local diseases. In its most general sense, the "seasoning" process referred to a period of settlement in which diseases and other hardships "became a particularly direct form of natural selection which took both stamina and luck to survive". Settlers who crossed the country were expected to experience this seasoning process for the first few years, after which they were acclimated. The actual illness referred to was usually malaria (ague, chills). Malaria became so prevalent on the frontier that it was accepted as a normal part of life there. People with chronic malaria could predict the cycles of chills and fever, so they could schedule their activities in the interims. The disease was common in San Francisco and outlying communities (see Chapters Five and Eight). There was a common belief that long residents were immune to other infectious diseases, such as yellow fever (Ackerknecht



1945: 24; Shryock 1960: 85; Jones 1967: 256-258; Findley 1968: 36; Thompson 1969a, b; Duffy 1974: 332; Brieger 1976: 31; Cassedy 1977: 42; Ellis 1977: 190, 211).

Irregulars who communicated popular health ideas expressed beliefs in the association between health, disease, and climate. The Family Health Annual published in Oakland by the Eclectic sect placed great emphasis on the dangers of seasonal diseases. In January staying indoors to avoid the cold resulted in the spread of smallpox, measles, scarlatina and other diseases, especially in the poorly ventilated dwellings of immigrants. In February rain brought croup, diphtheria, pneumonia, and colds. The sudden changes of temperature and cold winds of March produced throat ailments. This changeable weather continued in April, bringing biliousness and "spring sickness". Housekeepers were advised to be especially vigilant in their search for "disease germs and noxious gases" that month, such as in an outbuilding or near a cesspool; "before the warm sun of the succeeding month creates it into a hot-bed of disease". In May thorough spring cleaning was to take place "garret to cellar". It was a "sacred duty" to cleanse away "every taint of filth".<sup>3</sup> In spite of these efforts, June heat brought putrefaction of decaying matter and subsequent bowel disturbances. And in July convulsions were produced by dysentery and disordered digestion resulted from bad air, water and food. In August infant mortality became "really appalling" from cholera infantum, diarrhea, and dysentery. These diseases again resulted from poor air and food as well as drinking iced drinks and eating ice cream during hot weather (hot/cold theory). September brought the "autumnal fevers", i.e., malaria, which continued into October. In addition, one had to start wearing "warm suits of underclothing" to avoid the chills that

caused colds and influenza. Typhoid, typhus and scarlet fever occurred in November when many women and children confined themselves indoors in poorly ventilated rooms. December was the most fatal month for consumptives whose lungs gave out also from staying in stuffy rooms. It was important for them to get sun and air outside, warmly dressed, of course (The Family Health Annual 1878).

The dampness of California's winter wet season was especially cited as dangerous in this advice:

Mold frequently makes its appearance, adding to the chilling dampness another danger, that of germ poisoning. Vapors laden with organic matter ascend from the kitchen...condense upon the cold walls of unwarmed rooms. Soon, decomposition of the organic matter begins, and poisonous germs and gases are developed. Colds, croup, diphtheria, catarrh, consumption, rheumatism, neuralgia, goitre, cerebrospinal meningitis, and numerous other diseases originate in the damp dwelling rooms (The Family Health Annual 1878: 3).<sup>4</sup>

The future labor leader Frank Roney remarked in July 1875: "It seems as if this climate was not going to agree with me. The variety of weather one gets in San Francisco in a day is enough to satisfy the most fastidious for almost a season" (Roney 1870-1876: 7/1875). Edward Robbins Howe agreed, preferring life in Oakland to "blustering winds and raw fogs of San Francisco," which badly affected his health (Howe 1869-1874: 8/28/1870).

Beliefs in the association between climate or meteorological events and disease continue at the folk level to this day. Among some Black Americans natural phenomena such as season of the year have an effect by sympathetic magic on bodily health. People must be able to read climatic "signs" (Snow 1974: 88). Farmer's almanacs are used to provide advice on such natural indications. Chapter Eleven explains how such almanacs were a successful 19th-century promotional technique for certain patent

medicines.

### Summary Chapter Nine

Popular etiological beliefs about disease in the 19th-century reflected distinctions that are made cross-culturally concerning the immediate (or instrumental) and ultimate (or predisposing) causes of illness. Immorality, sin and the wrath of God might be regarded as the ultimate causes of an illness that was immediately transmitted by contagion. Physicians could not accept the idea of contagion in the 1870s but they agreed with the popular view that the living conditions of lower and immigrant classes were responsible for high disease rates.

Nineteenth century domestic health manuals emphasized the necessity of good diet and hygiene to maintain systemic balances in the body. This view reflected the cultural ideology of the body as an equilibrium model. Illness was a violation of some natural law. Moderation was the key to good health. Obedience to nature replaced obedience to God. In the case of urban immigrants, the victims of disease were blamed for causing their own fate through immoderate behavior. They became the focus of popular beliefs about disease contagion.

Furthermore, any excessive behavior might be passed on as an inherited predisposition to one's children. Thus immorality became an inescapable and fatal characteristic of the poor. Anyone might inherit a constitutional type or temperament that predisposed him to certain afflictions. Physicians believed in and prescribed for individual "diatheses" or temperaments. Whole races or nationalities became characterized by certain modes of pathology. The actual occurrence of disease became socially constructed and interpreted. These beliefs justified

social sanctions such as the health department's periodic clean-up and close-down attacks on Chinatown.

Other folk or popular beliefs about disease etiology included the hot/cold theory, and the avoidance of any extremes of temperature, work, exercise, eating, or sleeping. Excesses of all kinds weakened the body and made it susceptible to disease. These beliefs are illustrated in contemporary letters and diaries. People were concerned more with the how and why of disease and its implications than with its etiology and treatment. Their social or cultural construction of "illness" thus differed from that of the physician who brought the individual experience into his systematized conceptions of "disease". People shared the physicians' equilibrium model of the human body and attributed illness episodes to immoderate behavior, including the stress of urban life. They feared that the excesses of crowded immigrants would create communicable diseases reaching all classes. Unemployment, overcrowding, anxiety and overwork and consequent excesses in self-indulgence obviously resulted in disease in this conception. Moderation and regular habits were recommended, as they are today, to preserve one's health.

Additionally, climatic changes determined health and disease. Again extremes or sudden changes of temperature, winds, and other features were regarded as deleterious, and certain seasons brought characteristic diseases. San Francisco's cold, rain, and fog were blamed for many ills. In Chapter Fourteen I shall describe how climate was regarded as therapeutic as well.

Endnotes Chapter Nine

<sup>1</sup>Confirming these American attitudes, Haley (1978) notes that in Great

Britain among the middle and upper classes there was no clear distinction between mind and body, whether mind implied a religious, social, or moral condition. Upper class people believed in a mental or moral ultimate cause and a physical immediate cause for poor health. Health and disease were thus indicative ultimately of general societal well-being (Haley 1978: 11, 21-29, 45, 59). The general populace there had accepted a contagionist explanation of disease since their 14th-century experience with plague. But they blamed its spread on outcast groups, suggesting a moral component as well (Winslow 1943: 88-108).

<sup>2</sup>It was common in the 19th-century to define good health in terms of appetite and weight gain. Women at that time, quite unlike women today, proudly announced increases in their weight. For example, Hannah Bourn Ingalls was pleased to write her husband when she went from 142½ to 145 pounds. She aimed for 150 pounds, and hoped not to lose that weight (Ingalls 1865-1866: letters 5, 8, 11).

<sup>3</sup>In her history of housework, Susan Strasser notes that no one liked the upheaval of spring cleaning. She quotes Emily Dickinson, who said, "'I prefer pestilence'". It was a purification ceremony, accompanied by the taking of tonics in the spring to cleanse the blood (Strasser 1982: 62-63).

<sup>4</sup>Having lived in several turn-of-the-century San Francisco dwellings through the winter wet season, I can attest to the conviction that damp and mold breed headaches, sore throats and runny noses.

## CHAPTER TEN: SECTARIAN ALTERNATIVES

Medical sects appeared in the United States in the 1830s when Thomsonianism, hydrotherapy and homeopathy became popular. There were numerous other sects that came and went as well, but these three were most successful. The Thomsonian sect promoted self-treatment with herbal or botanic medicines (Berman 1951). Hydrotherapy involved water cures, usually conducted at spas. Its advocates, like the Thomsonians, eschewed professional medicine (Weiss and Kemble 1967; Legan 1971a). Homeopathy was, and is, a professional medicine, requiring medical education (Rothstein 1972; Numbers 1978).

"Vital Power": The Eclectics

The Thomsonian movement is of interest because the eclectics, so much discussed in 1870s San Francisco, were an off-shoot of this sect.<sup>1</sup> Initially Thomsonianism, with its emphasis on self-treatment and herbal cures, was a reaction against the harshness of regular, heroic medicines. It was additionally "a crusade to protect the people against the monopolistic designs of the 'Mineral Faculty'" of regular medicine (Berman 1951: 406). Thomsonians emphasized the restoration of body heat through the use of emetic lobelia, cayenne pepper, and steam baths. These techniques earned them the epithet, "steam doctors" and "puke doctors" (Berman 1951: 413; Coulter 1973: 91-101; Numbers 1977: 49). Such approaches have regained popularity in the wholistic health movement of the late 20th-century.

Definitely anti-establishment, Thomsonianism disappeared as its approaches became institutionalized. The movement fractured into splinter groups debating the value of training and professionalization. The eclectic group later established their own colleges and journals. Known

as "progressive Thomsonians", they added standard medicine to the botanicals. When eclectic practitioners split from the Thomsonians they designated themselves as Medical Reformers. They had a national association by 1850 (Wilder 1901; Berman 1951: 424-427; Young 1961: 44-57; Rothstein 1972: 127-151; Numbers 1977: 50-57).

Dr. John Scudder, leader of the eclectic sect, or "high priest of the order" according to the regulars, said in 1869: "We object to allopathic practice, whether it is pursued by those who call themselves regulars or eclectic. We propose to dispense with harsh, unpleasant, and antiphlogistic remedies, substituting those that act kindly and pleasantly, and increase vital power" (PMSJ Nov. 1869 No. 30: 278).

In 1874 the eclectics organized the Eclectic Medical Society of California with its own board of medical examiners. The regulars responded by suggesting that "These 'Eclectics' are a curious folk....The first and only distinctive article of their creed is that they shall not be at liberty to choose certain remedies. With such a creed there is no cohesion among them" (PMSJ 1875 XVI(8): 402-403). In 1879 the California Eclectic Medical College was established in Oakland. The school moved to San Francisco in 1888, having "the distinction of being the only Eclectic Medical College on the 'Pacific Slope'" (Wilder 1901: 729).

Eclecticism was defined in 1877 by one of its local adherents, J. H. Bundy, in his annual address to the Eclectic Medical Society of California: "our system of medicine is that above all others -- a system based upon the special pathological deduction, that disease is an impairment of vitality, and correlatively requires and demands a conservation of the vital forces" (Bundy 1877: 6). Bundy declared that it was not a sect, but a scientific understanding of disease etiology and treatment. Eclectics

recognized the advances being made in Natural Philosophy; i.e., in anatomy, physiology, organic chemistry. They condemned regular physicians for relying simply on nosology for therapeutic choices. The eclectics viewed themselves as medical reformers:

Eclecticism seeks to build up, strengthen, and support, aiding, in every possible way, the natural vital powers of the system to overcome disease. Allopathy teaches depletion...in its blind endeavors to rid the body of one affection by substituting another. Eclecticism.... professes to have remedies which exhaust themselves upon the disease...so that when the disease is removed, the remedy goes with it (Bundy 1877: 6-7).

Bundy stressed that medicine was in a time of transition and conflict, and that eclectic physicians felt a responsibility to keep up with these currents of thought and change.

That the average person was cognizant of the fine points of medical and etiological debate among the sects is very doubtful. But belief in vital powers or forces of the body was popular. The theory of vitalism suggested that disease was an imbalance in the body's vital force that required correction.

This belief was formulated for popular consumption by local eclectics in the Family Health Annual. It was published by the Pacific Press of Oakland, associated with the Oakland Health Institute, of which J. H. Bundy was one of the proprietors. It, in turn, was associated with the Battle Creek, Michigan College and Sanitarium, which were supported by J. H. Kellogg.<sup>2</sup> In addition to advice about hygiene and diet disseminated by The Family Health Annual, the Oakland Health Institute offered various forms of treatment, including "Turkish, Roman, Russian, Magnetic, Electric, and all Medicated Baths. Vacuum apparatus for Paralysis, Rheumatism, Lung Affections, etc. Health-lifts for strengthening and restoring muscular power...Lying-In Rooms" (The Family Health Annual 1878).



Regular physicians in San Francisco were so contemptuous of this approach that they published frequent barbs about the eclectics. For example, in 1872 they quoted from the American Eclectic Medical Review a self-defeating catalog of endless symptoms of indigestion (PMSJ 1872 VI(1): 49-50). In 1880 they continued to make fun of the eclectics when they announced the start of the California Medical Journal (PMSJ 1880 XXII(9): 426-427). At this time the Medical Directory of the Pacific Coast listed the names of 1,190 regular physicians in California, 141 homeopaths, and 190 eclectics (PMSJ 1880 XXIII(5): 221). The San Francisco Directory listed one botanic physician, Robert H. Cowen, in 1871. Mrs. C. A. Cook was added in 1873, along with an eclectic physician, G. W. Eggleston. In 1875 another City Directory listed two botanic physicians, T. M. D. Fillmore and Mrs. C. O. Regal; and five eclectic physicians. One of the latter advertised himself as "Dr. H. N. Miner, Eclectic Physician Prof. of Obstetrics, and Practical Accoucheur. Thirty Years Practice. Private Diseases a Specialty" (Langley 1871, 1873; Bishop 1875: 1190).

### Water Cure

The eclectics used various kinds of therapeutic baths for their patients. Hydrotherapy usually took place in special water-cure establishments (see Chapter Fourteen).<sup>3</sup> It included drinking mineral waters as well as bathing, exercise, massage, sweating, drugs, and heat (Legan 1971a: 268). The treatment appeared in America in the 1840s. In the form of Grahamism and under the leadership of John Harvey Kellogg, modified hydrotherapy continued into the 20th-century (Shryock 1966b; Weiss and Kemble 1967: 67; Legan 1971a:279; Numbers 1977). Many water-cure practitioners

were women and feminists. The Water-Cure Journal edited by Joel Shew and Russell T. Trall advised people on home practice of these approaches, as did the later hydropathic journal, The Health Reformer, published by Seventh-Day Adventists (Numbers 1977: 63-68).

The City Directory of San Francisco listed Water Cure physicians each year in the 1870s. Barlow J. Smith advertised "Dr. Smith's Hygeian Home Water Cure". He said it was the largest Hygienic Institute on the West Coast. He seemed however, to rely heavily on the practice of phrenology, by which he diagnosed such diseases as consumption, dyspepsia, neuralgia and rheumatism. Patients were able to board at his establishment and take "Electro, Russian, Turkish and Thermal Baths, and every form of Medical Baths for Ladies and Gentlemen" (Langley 1871: xcvi). In 1873 he added that he could cure such diseases as "Constipation, Erysipelas, Scrofula, Piles, Inflammation of the Bowels, chronic and acute; Diarrhoea", as well as lung problems and paralysis (Langley 1873: 48).

An opulent Turkish bath, the "Hammam", was established on Dupont Street by a Doctor Loryea who "decided that the climate of California was the more favorable wherein to demonstrate the benefits of the hot-air bath". It duplicated the surroundings of famous sanitary spas of Europe. The perspiration produced by these baths was thought to be beneficial to skin and lungs (Lloyd 1876: 343-348).

People of all classes did try various types of water cure. The Kingsley family, farmers of Red Bluff, California, occasionally took steam baths locally for their health (Kingsley 1874). Harriet Lane Levy reminisced about her childhood in the 1870s:

Every summer we were taken to the mountains to drink the waters of some medicinal spring....We were all possessed of unimpaired digestion, but Father relished the easy sociability of the springs and, once there, felt it would be wasteful not to profit by medication offered free to guests. Water, potent to cure the disordered stomach, must surely be able to prevent trouble, he reasoned, and he forthwith established a rigorous regime for himself and his family, drank deeply and often, and returned home enthusiastic and sunburned, declaring that he had never felt better, forgetting that he had never felt worse. The following year we would seek new waters and lay the family kidneys upon the altar of his radiant faith (Levy 1975: 67-68, orig. pub. 1937).

Some regular physicians were sarcastic about the water-cure approach; others recommended it. Dr. Clemens M. Richter, a German physician who arrived in San Francisco in 1872, commented that Dr. Zeile there "had been a pioneer, wore a rich fur coat when driving, ordered steambath as the sovereign remedy for most ailments (he owned the steambath building) and never had time to examine a patient". In spite of his criticism, Richter inherited Zeile's patients (Richter 1922: 16).

Mrs. Joseph Newmark wrote in the late 1870s that her sister became ill and was treated for four weeks by "Dr. Tyrel, the best doctor in Sacramento". He advised her to visit the baths at Karlsbad, Germany. So she went there with her two children. Mrs. Newmark said, "The trip helped my dear sister very much. The spring water and the mud baths in Karlsbad strengthened her. They were in Europe two years so that they might visit Karlsbad again" (Newmark 1900: 11). Some years later the illness returned, and her sister became deaf, paralyzed and mentally weakened before she died (Newmark 1900: 15).

#### Electro-Magnetic Treatment

Electro-magnetic treatment was apparently quite popular in San Francisco. The City Directory listed five such physicians in 1871, two

of them women. There were eight in 1873, and nine in 1874, only six or seven for the next few years, and then twelve in 1879 (Langley). In 1870 the leading medical journal poked fun at an ad for the "Director of the Homeopathic Healing Institute" who claimed to heal spinal complaints by what was actually hydrotherapy. He used "'specific healing baths'" containing "'A galvanic magnetic fluidum'" that "'annihilates the dynamical powers of all disease, causes and animates the organic activities so thoroughly that all disturbances are equalized, all foreign matter expelled through beneficial perspiration, and all parts of the organism brought back to the normal state of health'" (PMSJ Sept. 1870 No. 40: 183). The editors were sarcastic about this treatment, but they did not point out that it was clearly not homeopathic. It was a well known approach. Gertrude Stein's mother Amelia received extensive galvanic battery and salt bath treatments in the mid 1880s from a Dr. Fine in Oakland. She received the electric treatments almost daily at the doctor's office and then took the salt baths at a sanatorium. This doctor was also their general practitioner (Stein 1878-1886).

The popularity of electromagnetism and electric therapy began in the late 18th-century. In the 19th-century it was continued through Dr. Elisha Perkins' "metallic tractors". Perkins believed that touching the body with these gold and silver points would draw off dangerous electricity which accumulated and produced disease. Many subsequent electromagnetic therapists advocated either drawing electricity from the body or adding it. They manufactured magnetic belts, electric wrist bands, cravats, anklets, elbow pads, necklaces, head caps and corsets (Young 1978: 97-102).

Dr. F. V. Hopkins wrote a series of articles in 1875 on his use of

electricity in therapy. He remarked that it was not popular with physicians because they questioned claims that it could cure anything. It was also distasteful to some physicians because,

The application of the electrode to nerve after nerve, or muscle after muscle of a patient's body, is an almost menial process, not exactly consistent with the dignity whereof the dashing turnout, heavy watch and gold-headed cane are the fitting accompaniments. It is rather too suggestive of the duties of a shampooer at the baths, or of the ancient connection of the tonsorial and chirurgic arts (Hopkins 1875: 110).

He had successfully used electric treatment for "chronic catarrh of the intestines, retroversion with endometritis and reflex paralysis of lower limbs". But his attempts to use it on consumptive patients had been unsuccessful.<sup>4</sup>

#### Similia Similibus Curantur: Homeopathy

Homeopathy appeared in the United States by 1825, and became a major medical sect by the 1870s. It originated with the German physician Samuel Hahnemann who died in 1843 (as did Samuel Thomson). A complicated theoretical system, it has as a keynote the law of similia similibus curantur, treating like with like. Homeopaths termed regular practitioners "allopaths" because they used medicines that acted in opposition to symptoms.<sup>5</sup> Homeopaths treated a symptom with a remedy that would, in large doses, produce the same symptom (Rothstein 1972: 153; Coulter 1973; Numbers 1977). Levels of dosage of homeopathic medicines were low and became increasingly smaller as treatment progressed. The "medicinal disease" produced by treatment replaced the actual disease and was gradually extinguished by the "vital principle" (Wilder 1901: 320).

Most homeopathic doctors were trained as regular physicians. Their clientele tended to be upper class and aristocratic. Consequently, this

sect became the most competitive with regular practitioners. It was especially popular because homeopathic treatments did not produce the harsh side effects of regular medicine and the equally rigorous early Thomsonian approach. Women appreciated the domestic kits for home practice of homeopathy, and its gentler effects on children (Rothstein 1972: 160; Numbers 1977: 58-62).

By the 1860s and 1870s both regular physicians and homeopathic physicians in America altered their materia medica, as we saw in Part Two. As the regulars eliminated calomel, bloodletting and other heroic treatments, the homeopaths began to question the doctrine of infinitesimal dosages. Some homeopaths adopted regular medicines. By the 1880s the sect had divided into purists and eclectic homeopaths. The latter group became more and more legitimized. The California Medical School in San Francisco merged with the city's Hahnemann Medical College and taught homeopathy to those who wanted it into the 20th-century (Kaufman 1971: 110-113, 121-123, 149, 171; Haller 1981: 104-126). As with many of the other alternatives of the period, homeopathy is having a current resurgence in the Bay Area.

In 1874 San Francisco homeopaths provided the public a lengthy explanation of their medical theory:

A FEW WORDS about HOMOEOPATHY. Homoeopathy is the only system of medicine that has a fundamental and unvarying law as a guide in prescribing for the sick. This law is expressed by the formula, similia similibus curantur, or like cures like....The various drugs, animal, vegetable, and mineral...have very different effects. The knowledge the Allopathist has of these effects is derived from experiments made on the sick; it is therefore inaccurate, and is arrived at only after much unnecessary suffering, and many untimely deaths have marked this fearful road to knowledge. The Homoeopathist...takes a given drug himself, in varying doses, and gives it to his friends of different temperaments and conditions, all being in good health, and carefully watching every effect produced,

records the pathogenesis or disease-producing power of that drug....under the homoeopathic law...a drug should cure symptoms and conditions of disease similar to those it will produce (Homoepathic Guide for the People 1874: 10-12).

The guide advised on the purchase and storage of prescribed homeopathic remedies and recommended specific treatments. For example, Arsenicum or China was recommended for the chills and fever of ague. Aconite or Spongia were to be given for the cough of croup, and Tartar Emetic if there was difficulty in breathing. Aconite was recommended for all forms of fever; but Pulsatilla and Belladonna were also suggested as preventives against whooping cough, measles, and scarlet fever (Homoepathic Guide for the People 1874: 18-27).<sup>6</sup>

The regular profession was critical of homeopathy throughout the decade of the 1870s. In 1879 they stated sarcastically, "The number of homeopathic physicians in the United States fifteen years ago was estimated at 5000. The number stated in the Homeopathic Directory for 1878 is 5000. They are in a state of lively fermentation at present" (PMSJ XXI(8): 384). Homeopathy was popular among the people however, a fact with which the profession had to cope. The City Directory gives an idea of how many such physicians were available. There were 11 homeopaths in 1871, 18 in 1873, 19 in 1874, 21 in 1875, 23 in 1876, 24 in 1877. They were not listed separately in 1878 and 1879, perhaps because the medical law had legitimized them so that they were included in the list of regular physicians. People in good society sought homeopathic treatment. For example, Edward Howe wrote his aunt in 1871:

I have suffered awfully with dyspepsia....You may be pleased to hear that I have been trying the effect of homeopathy lately, and I think I feel better for a little dosing. Soon after coming here I made the acquaintance of a young homeopathic physician who had

graduated at the medical school in New York, and who seems to understand his business well. I think it better to be treated by a physician who knows you well & takes an interest, more than the common, in you. About a year ago he did me a great deal of good by a little timely administration of physic (Howe 1869-1874: 3/1/1871).

Three common reasons for preferring homeopathy are expressed in this letter: because of its milder medicines, because the physician shows special interest in the patient, and because he is a medical school graduate. These were major attractions of homeopathy.

In 1877 a Bay Area society matron wrote to her aunt from a trip back east that both her children had been troubled with severe coughs. She diagnosed her son as having an attack of croup (laryngeal obstruction). She reported that,

I used what remedies I could then get - molasses vinegar & cold water, and as I have quite a large collection of homeopathic medicines with me, and a most excellent book of directions, I gave him doses every 15 minutes until 6 in the morning when he seemed better and went to sleep (Pierce 1869-1888: 3/18/1877).

She found however, that a cure came about through use of a friend's recommended "wort syrup, which acted like a charm". Another appeal of homeopathic medicines was that one could doctor oneself, as Mrs. Pierce did when travelling.

Military people in unsettled and remote areas used homeopathic remedies. For example, Robert LaMotte was an army captain who had left San Francisco to serve in Kansas and Montana. He wrote his mother about life there with his wife and small son in the late 1860s. His mother was especially interested in details about her grandson Harry. In April 1867 LaMotte wrote her:

homeopathy has done him so much good that he is now almost, if not quite his old self. First he had a high fever, which I got rid of with one dose of



Aconite. He then had headache - his head burning hot - hands & feet cold - moaning & crying if moved. This gave way in a couple of days to Belladonna - and then he had colic starting out of his sleep screaming - but Chamomilla stopped that - and now he seems clear of all his troubles (LaMotte 1849-1872: 4/13/1867).

A month later the child developed whooping cough:

He still has occasional bad spells of coughing, and whoops unmistakably, but I have given him Belladonna, and latterly Drosera which I think relieves him very much. I have more confidence in my doctoring than I thought I should have - and Nellie, though she professes to have no faith in homeopathy, still she watches Harry closely, and says it acts beautifully on him (LaMotte 1849-1872: 5/20/1867).

LaMotte ordered more homeopathic remedies the next year (LaMotte 1849-1872: 8/27/1868).

#### Summary Chapter Ten

The sectarian medical alternatives available to San Franciscans in the 1870s included homeopathy, hydrotherapy and electro-magnetic treatment. The eclectics carried on the tradition of botanic medicine. The homeopaths and eclectics each organized themselves into local medical societies and colleges. Eclectics regarded themselves as medical reformers, opposed to regular "heroics" and stressing instead the body's natural "vital power". Disease was an imbalance of bodily systems. Thus the eclectics shared popular beliefs in the homeostasis of the human body.

Hydrotherapy usually occurred in special establishments where patients drank water, bathed, exercised, sweated and were massaged. Many eclectic physicians included this approach in their repertoire. Hydrotherapy carried on the European tradition of health spas and the curative powers of spring water. It was often accompanied by forms of electro-magnetic treatment in which bath water was "magnetised" or electrodes were touched to nerves and muscles.

The most respected sectarian alternative was homeopathy. This approach originated in the early 19th-century by Samuel Hahnemann, remains a popular alternative to this day. Patients tended to come from the upper classes and appreciated the mildness of homeopathic medicines. These medicines were available to people for home prescription and use, although this practice was discouraged by homeopathic physicians. The San Francisco City Directory listed members of the medical sects as well as regular physicians each year. Though fewer in number, the sectarians clearly attracted a following of patients who were discouraged by the therapeutics of regular doctors.

#### Endnotes Chapter Ten

<sup>1</sup>Eclectic became a term applied to a number of different kinds of "irregular" medical practitioners, as the name implies. They were usually not trained in "regular" schools, and rejected most heroic medicines.

<sup>2</sup>By the 1890s a branch of the Battle Creek Institute was established near San Francisco at the Kellogg's spa at St. Helena in the Napa Valley, where some health spas survive today (Anderson 1890).

<sup>3</sup>There is a long history to water cure, dating from classical times. Hydrotherapy was brought officially to America by Vincenz Priessnitz in the 1840s; but forms of it had been practiced there as early as the 1830s (Weiss and Kemble 1967: 1-19; Legan 1971a: 268-271; Numbers 1977: 62).

<sup>4</sup>For more on electro-magnetic therapy, see Haller and Haller(1974: 13-23).

<sup>5</sup>The term allopath was first used by Samuel Hahnemann. It derives from

Greek *άλλος*, other or different, and *πάθος*, or suffering. Thus it implies curing disease through inducing another kind of suffering.

<sup>6</sup>Arsenic was used as a tonic; China was a root similar to Sarsaparilla; Aconite was an extract from the poisonous plant also known as Wolf's Bane. Belladonna (Deadly Nightshade) leaves and roots contain the active alkaloid atropine, a depressant; Pulsatilla was extracted from a species of Anemone flower (Oxford English Dictionary). The San Francisco publishers of this homeopathic guide, Boericke and Tafel, are today major distributors from Philadelphia of homeopathic products (e.g., see ads in Whole Life Times).

## CHAPTER ELEVEN:

## "SIX OUNCES OF A DARK RED SYRUPY LIQUID": PATENT NOSTRUMS

The "great patent medicine era" in the United States was well under way by the 1870s. These medicines derived from a long history in which cures were regarded as especially efficacious if secretive. Patent medicines often retained an air of the magical or occult, responding to people's beliefs in supernatural disease causation.

As the regular profession increasingly sought justification of its activities in science, patent medicines offered the public the possibility of magic. In Bronislaw Malinowski's classical distinction, "Science is founded on the conviction that experience, effort, and reason are valid; magic on the belief that hope cannot fail nor desire deceive" (Malinowski 1948: 87). The regular physicians were attempting to gain hegemony over medical practice in San Francisco by rationalizing their beliefs and practices as empirical and scientific. As we saw in Part Two, they actually relied as much on mystification as did any of the alternative practitioners. But patent medicine manufacturers capitalized on the advantage of openly appropriating magic and mystery. The general public, concerned with prognosis, looked for reassurance that they would be cured; that both the physical disease and its possible origin in wrongdoing could be erased. As physicians increasingly presented the mental world and vocabulary of science they defeated their own efforts to compete with "quacks". Patent medicines could offer magic that was able "to ritualize man's optimism, to enhance his faith in the victory of hope over fear" (Malinowski 1948: 90). It is not surprising that so many of these medicines used the actual words magic, miracle, and mystery in their names.

Patent medicine manufacturers secured their hold on such beliefs about healing by obtaining copyrights on the labels or literature which described their nostrums,<sup>1</sup> without revealing actual contents. There were thousands of such medicines, but few obtained patents because they required revelation of ingredients (Young 1961: 40). Since the term patent medicine was more popular than the alternative proprietary medicine, I shall use it in spite of its inaccuracy.

The spread of newspaper advertising in the United States produced great popularity for these medicines. The usual approach was to advertise long lists of general symptoms, such that anyone might identify him or herself as ill. Examination of patent ads reveals the use of every advertising ploy from sex to exploitation of fear. Beautiful young women glowed with health, death's heads and distorted bodies illustrated disease. Exotic sources of cures were claimed. Testimonials were widely used, often from professional men, clergymen, regular physicians, as well as cured patients. Some testifiers were convinced that the remedy worked, others were paid for their recommendations (Young 1961: 176, 183, 188). Often these remedies did work, as purges or laxatives bringing relief to Americans who typically overate and ate too fast.

Promoters of patent medicines were often dishonest about their ingredients. Patients sought alternatives to the harshness of regular practice; but patent remedies often contained mercury, alcohol and opium.<sup>2</sup> They operated under a laissez-faire economy in which American cultural values venerated success, not ethics. It took many years for the regular profession to achieve enough success to permit ascendancy of its own ethics. The patent medicine salesman shared the businessman's ethic of shrewd practice (Young 1974: 5). Competition among patent manufacturers was

fierce and few reached the level of the big advertisers. They promoted their products not only in newspapers but in free literature left in stores and delivered door-to-door. They advertised in mail-order catalogs, even in novels. They formed trade associations (Young 1961: 103-108).

Patent medicine promoters developed the idea of distributing almanacs to reach the public. Some were farmers' almanacs, others cookbooks, books on home remedies, or children's books (Hechtlinger 1970: 127). The most famous, Ayer Almanacs, were translated into 21 languages to reach the immigrant population. Dr. Hostetter, who sold his Celebrated Stomachic Bitters Tonic, put out an almanac in California in the 1870s. Almanacs created and reinforced popular American culture, as did mail-order catalogs. In spite of their effort to get the business of immigrants, almanacs typically presented cruel ethnic cartoons, caricaturing Irish, Jews, Blacks and American Indians.

These manufacturers sold books that gave general medical advice as well as advertising their remedies and asking for orders.<sup>3</sup> Such books did in fact educate people. As is true today, useful advice about preventive care and hygiene rarely came from professional physicians, who concentrated on treating and curing established disease. Someone referring to W. W. Hall's 1869 The Guide-Board to Health, Peace and Competence would have found advice on such topics as bathing, marriage, exercise, sleeping in the same bed, rapid eating, tea and coffee, foul air in unventilated places, care of the hair, use of tobacco, and so on. Hall also advised that cholera was transmitted by a debilitated race of people. They were predisposed to cholera by their "vicious indulgence" in vice, which produced a life of filth and squalor. Through contagion the dis-

ease spread to the honest poor and to the wealthy whose "voluptuous" habits brought them to "infected dens" (Hechtlinger 1970: 83).

Readers of almanacs and books by purveyors of patent medicines were early informed of incipient germ theory. The manufacturers quickly capitalized on claims that their nostrums were germ killers (Young 1961: 144). They could easily adapt their flexible views on etiology of disease to include germ theory. They were able to profit from the grave state of transition of the regular profession. For example, R. V. Pierce, in The People's Common Sense Medical Adviser published in 1889, explained medicine to his readers. Shrewdly rejecting the term, patent medicine, since he had never applied for patents, Dr. Pierce said his remedies were "simply favorite prescriptions". He then enlightened his readers as to the classes of medicines (alteratives, anodynes, anti-periodics, cathartics, diaphoretics, emmenagogues, liniments, nervines, stimulants, tonics). His Golden Medical Discovery was an anti-periodic for cure of malaria and other miasmatic diseases. It neutralized poison in the system and produced its excretion without the bad effects of quinine (Hechtlinger 1970: 183-189).

Many patent medicines deliberately excluded ingredients found in regular medicines, such as quinine or calomel. Most in fact relied on alcohol. For example, Hostetter's Bitters was 44 per cent alcohol. Patent medicines also contained opium and morphine and various minerals such as iron, steel, creosote and petroleum. In addition, they contained the traditional herbs and home remedies that had been recommended as cures at an earlier time. In 1877 the Pacific Medical and Surgical Journal published the contents of 12 patent medicines. They quoted directly from Steiger's Popular Health Almanac. For example, Ayer's Ague Cure was,

six ounces of a dark red syrupy liquid, with a slight white sediment, a very bitter taste, and an odor of winter-green oil. It consists of an alcoholic tincture of cinchona bark, with the addition of about three grains of quinoidine and three grains of sulphate of cinchonine for each fluid-ounce, dissolved by the aid of sulphuric acid; it is sweetened with sugar and flavored with oil of winter-green. The white sediment consists of sulphate of lime.

And Jayne's Ague Mixture:

Each bottle contains  $7\frac{1}{2}$  fluid-ounces of a mixture having the odor and taste of rhubarb, dandelion, and common molasses. It contains sulphate of quinine and traces of other cinchona alkaloids, but not enough to render the mixture very bitter (PMSJ 1877 XIX(8): 375-376).

Patent medicines could be dangerous. But by the 1880s and later alcohol tended to replace more dangerous substances such as antimony salts, capsicum, methylated spirits and cannabis. People spent much of their money on patent medicines when they were sick, but probably less than they would have wasted on the usually ineffective treatments of doctors. And they felt some personal control over their situation (Smith 1979: 345).

Although the American Medical Association and the American Pharmaceutical Association were both organized in part to protest patent medicines and other forms of "quackery", effective legislation was not passed until the 20th-century. The Food and Drug Act of 1906 was greeted by tremendous opposition among patent medicine manufacturers (Young 1961: 244). Current controversies propose legislation to control "quackery" in 1980s San Francisco (Public Affairs Research Group 1981).

Many people disliked and distrusted regular medicines in San Francisco. The homeopaths suggested that people avoid all regular, and patent, medicines. For example, they opposed the use of quinine in malaria treatment: "It may stop your ague, but leaves a worse disease behind, the quinine disease, from which you may be years in recovering". Homeopaths



recommended home treatment with their remedies only under a physician's direction, and warned against medicines sold as homeopathic "specifics". They criticized other "domestic medication": "the amount of suffering engendered and perpetuated, and the amount of money wasted annually by the purchase and domestic use of hurtful drugs from the apothecary, or by quack nostrums and so-called panaceas, is almost incalculable" (Homoeopathic Guide for the People 1874).

Eclectic practitioners agreed. Speaking of child deaths, they argued that "Thousands of innocents are sacrificed by indiscriminate dosing with powders, pills, teas, and sundry other 'regular,' 'irregular,' and domestic compounds" (The Family Health Annual 1878; 17).

People commented on the side effects of medicine. For example, Carolina Kingsley noted in her 1874 diary that taking sulphur for "a breaking out" made her "almost sick". The medicine must not have helped her, for she remained ill for several more weeks (Kingsley 1874; 3/1874). Margaret Pierce referred to much of the medicine she took as "horrid", and she advised her aunt to eat more and "'throw physic to the dogs!'" (Pierce 1869-1888: 11/12/1874, 11/22/1874, 12/15/1874).

Physicians objected to patent medicines, but otherwise they had an accepted place among alternative practices in San Francisco. Guillermo Prieto, visiting from Mexico in the 1870s, left us a description which gives an idea of the lively presence of patent medicine purveyors and other alternatives in San Francisco:

A thousand tricksters, sharpers and charlatans display their wares by torchlight....a sage operates an electrical device for treating hemorrhage, rheumatism, dyspepsia, and every scourge of unhappy mankind. There a man has birds who predict the future by picking up bits of colored paper....On one street-corner a prestidigitator swallows wool and spits out flame. On another a charlatan

with a microscope probes the secret of a human hair or a drop of water....a torch reveals a box surmounted by a skull and the legend 'INFALLIBLE CURE FOR CORNS'.... a large wagon clatters ostentatiously along after a full team of four horses....The exterior bears on all its sides the large inscription: 'DOCTOR KINSWELBOURG UNIVERSITIES OF GERMANY AND PARIS THE GREAT CONFIDANT OF THE SPIRITS THE RIVAL OF MESMER IN MAGNETIC DISCOVERIES NATURALISM BOTANIST INCURABLE DISEASES ARABIAN ROOTS FOR WORMS SNAKE VENOM' (Prieto 1938: 28, 43-44).

Not surprisingly, the regular professionals were distressed to see this "charlatanism and quackery" all about them. In 1874 they felt it necessary to explain the origin of Hostetter's Bitters, which had become a popular nostrum on the West Coast. They revealed that "Doctor" Hostetter was a Greek immigrant bartender who cashed in on a concoction of "ordinary cheap whisky, with a little bitter decoction and essence of orange-peel" (PMSJ 1874 XVI(7): 359). Hostetter was indeed very successful in California. His wholesale agents in San Francisco distributed a number of patent medicines as well as the almanac mentioned earlier. The almanac advertised "Triumphs of Hostetter's Stomach Bitters in California, Oregon, Idaho, Colorado, and Nebraska". It stated that "this commanding Vegetable Tonic and Corrective" came to the aid of emigrants and miners in these states who, as a result of their privations suffered from "Periodical fevers, fluxes, dysenteric disorders, acute rheumatism, scurvy, and a host of other maladies". Many deaths had resulted from the use of standard heroic remedies, quinine and alcohol, until this "great Antidote to Epidemic Diseases" arrived on the scene (Hostetter's Almanac 1868).

In 1874 two respected members of the profession published criticisms of patent medicines. Prefacing his remarks with the notion that "'people like to be humbugged'", Henry Gibbons, Sr. provided a history of quackery. He blamed apothecaries and others for stealing the medicines of the regular profession, noting the example of an apothecary's ad for a cure for

whooping cough currently appearing on all the street cars in San Francisco. Gibbons posited that the physician is judged by his failures, and the charlatan by his successes. Thus lucky reputations were established for such patent medicines as Mrs. Winslow's Soothing Syrup ("one of the most dangerous nostrums in the market"), Swaim's Panacea, and Dr. James' Carminative Balsam (relieves flatulence). A typical example was the career of Doctor Young, "the pioneer quack of the Pacific Coast". Young was an upholsterer who "flashed into fame and into business through the institution which graduates nearly all the quacks in the world--the newspaper press", according to Gibbons. He recounted a tale in which a legitimate doctor was used by Young to prescribe for the patients while Young received the fees. This man may have been Benjamin F. Josselyn, who advertised in the 1870 Overland Almanac for the Dr. J. C. Young Medical Institute on Sacramento Street. The ad lamented the poisoning of ague sufferers by arsenic and mercury. It proposed that this "baffling disease" could be treated by "the rational knowledge of the causes of the disease" and cured, or money refunded (Overland Almanac 1870: 25).

Gibbons described the process by which men have taken natural sources such as wild cucumber, yarrow, and dogwood and turned them into bitters. These remedies were endorsed by clergymen and advertised in newspapers. Success was ensured for their "doctor" manufacturers. Lamenting the alcohol content of bitters, teetotaler Gibbons felt they were "little more than lures to drunkenness:

The formula then, for medicinal bitters in general, runs thus: Take of cheapest whisky, an indefinite quantity; of any bitter vegetable, herb, flower, root or bark, q.s: Mix, and flavor with anything or nothing. Put in bottles and employ an expert liar to write labels and certificates. Present a few bottles to editors and clergymen of taste. Advertise largely and sell for five hundred per cent. above cost of material (Gibbons 1874: 18).

At least in the latter part of this formula, the prescription is not different from today's legitimate drugs. One such medicine, advertised in 1868, was Bristol's Sarsaparilla, "The Great Spring and Summer Medicine". It was a blood purifier and cured scrofula and syphilis if taken along with Bristol's Sugar-Coated Pills. These pills were composed of roots, barks, flowers, leaves, plants and balsamic gums (Hostetter's Almanac 1868).

Gibbons also mentioned two well-known patent purveyors who had passed through San Francisco: Van Ehrenburg, who advertised heavily and disappeared in the night, and the "King of Pain" who sold aconite liniment (Gibbons 1874: 13). The English journalist, W. F. Rae, observed the King of Pain's methods in 1870:

He professed not only to cure all diseases, but also to inform the patient of his malady without asking any questions....Driving through the city in a handsome carriage, he halts now and then, and makes a short speech. While he is retailing some of the miraculous cures which he has effected, a passer-by having the appearance of a sailor, or a mechanic, stops and exclaims, 'What's that you say about Boston?' The quack replies, 'Sir, I have just told these gentlemen how Mr. John A. Jones, a prominent citizen of Boston, was cured by a single bottle of this specific after all the other doctors had given him up.' 'Well, sir, that's so. I come from Boston, and I know Mr. Jones was cured by a bottle of your medicine' (quoted in Lewis 1962: 173-174).

After selling a few bottles, the King of Pain moved on to another location to present a similar story.

B. E. Lloyd expressed little mercy towards "quacks" in his 1876 description of San Francisco life. He commented that "There is perhaps no city under the sun that bears so great a burden of charlatanry in medicine, in proportion to the population, as San Francisco". Some capitalized on the attractions of the name California, such as "Dr. Walker's Vinegar Bitters - a compound of the most nauseating and disgusting ingre-

dients, yet a 'CALIFORNIAN vegetable preparation, possessing remarkably curative properties,'" according to its promoter. Lloyd further observed that "quacks" in San Francisco focused on specific diseases resulting from the damp chill of the city, such as catarrh and rheumatism. Most exploited the high incidence of venereal diseases. He described a Dr. McBride, who called himself "a scientist, naturalist, botanist, and a graduate of the most noted medical college in Paris". He sold his patent medicines by travelling through the city with a coach and four, first with an emaciated patient, and then with a healthy one, supposedly the first man cured (Lloyd 1876: 360, 443-445).

Did people support the careers of these medicine men simply out of ignorance or simple-mindedness as physicians suggested, or was it because they found no relief in regular medicines and turned to alternatives as people with incurable diseases do today? A former San Franciscan and employee of a local newspaper, wrote to the mayor in 1874 expressing concern about the smallpox epidemic. He wished to communicate a simple, swift cure which had worked for him the year before and for four of his friends, without aid of physicians. He argued that he was not selling the remedy, just recommending it. The Pacific Medical and Surgical Journal printed his statement, but left out the name of the medicine. The editors commented on how incredible it was for a man of good sense to fall for such a cure (PMSJ 1874 VII(9): 481). Whether or not this man's statement was just a "puff", we know that regular medical treatments for smallpox did little more for this terrifying disease than whatever his cure entailed.

That patent medicines were extremely popular in San Francisco, as in other cities, is suggested by the very newspaper advertising to which

physicians objected. For example, in January 1870 and thereafter Dr. Aborn advertised a testimonial for his catarrh cure on the first pages of the Daily Alta California. The San Francisco Chronicle presented many medical advertisements. Sanford's Radical Cure for Catarrh appeared daily in 1877 in a long ad. Two ads appearing in this newspaper in 1878 were typical:

QUININE AND ARSENIC form the basis of many of the Ague remedies on the market, and are the last resort of physicians and people who know no better medicine to employ for this distressing complaint. The effects of either of these drugs are destructive to the system, producing headache, intestinal disorders, vertigo, dizziness, ringing of the ears, and depression of the constitutional health. AYERS AGUE CURE is a vegetable discovery, containing neither quinine, arsenic, nor any deleterious ingredient, and is an excellent tonic and preventive, as well as cure, of all complaints peculiar to malarious, marshy and miasmatic districts. It acts directly on the Liver and biliary apparatus, thus stimulating the system to a vigorous, healthy condition. For sale by all dealers (San Francisco Chronicle 9/4/1878: p. 2, c. 2).<sup>4</sup>

MALIGNANT AND SUBTLE INDEED is the poison of Scrofula, and terrible are its ravages in the system. They may, however, be permanently stayed and the destructive virus expelled from the circulation with SCOVILL'S BLOOD AND LIVER SYRUP, a potent vegetable detergent which eradicates all skin diseases, leaving no vestige of them behind. White swelling, salt rheum, tetter, abscesses, liver complaint and eruptions of every description are invariably conquered by it. Druggists sell it (San Francisco Chronicle 11/23/1878: p. 2, c. 2).

These advertisements expressed two of the most prevalent and worrisome diseases experienced in San Francisco at this time. They illustrate a number of popular medical themes. The use of regular medicines is deplored as dangerous and unpleasant. The importance of the constitution, biliary system and bloodstream are emphasized. Both miasmatic and viral theories of disease are suggested. The horrors of disease are played upon, but cures are assured.

Other patent medicines advertised in this newspaper included Boscher's

German Syrup which had "astonishing success in curing severe coughs, colds settled on the breast, consumption, or any disease of the throat and lungs"; Peruvian Syrup and Wistar's Balsam of Wild Cherry for "a cold on the lungs"; Hales' Honey of Horehound and Tar for consumptive coughs or violent colds of children; Shaw's Pectoral Syrup for cough; and Wistar's Children's Cough Syrup for diphtheria, croup and coughs (San Francisco Chronicle 1877).

Examples of the almanacs issued by patent medicine men appeared in 1870s San Francisco. Le Doyen's Pacific Almanac for the Use of Farmers, Miners, Merchants, and Families promoted Le Doyen's Sarsaparilla through the reminder: "HOW DREADFUL IS DISEASE! HOW JOYOUS LIFE! BEWARE OF POISONS!" Unlike heroic remedies, this medicine could be given to anyone without injury. It was used against all fevers and contagious diseases (Le Doyen's Pacific Almanac 1866).

People of all classes responded to such ads, to the dismay of regular physicians. The labor leader Frank Roney noted in his diary that he felt sick after drinking, and continued sick "after taking a new kind of bitters called 'D<sup>I</sup> Gunns". He nonetheless worked his usual ten hours that day (Roney 1870-1876: 2/5/1876). Hannah Bourn Ingalls advised her husband in 1866 of her success in treating her corns with "Dalley's salve" (Ingalls 1865-1866: 4/5/1866). Amelia Stein took her son Leo to see a doctor after several weeks of illness, and on the way home bought a box of "Dr Wie de Meyers catarrh cure" for him (Stein 1878-1884: 2/25/1884).

Recalling her childhood, Harriet Lane Levy described her mother's use of patent medicines. Physicians recommended "plasters," which could be homemade with flour and mustard, or bought as patent medicines:

'Alcock's Porous Plaster cures every ill,' announced the billboards, and everybody agreed that, for chronic dis-

comfort, it was the remedy. The porous plaster, once clapped onto the body, withstood temperature and water and survived weeks of baths and dryings, eventually to be parted from the skin after savage resistance (Levy 1975: 201, orig. pub. 1937).

### Summary Chapter Eleven

An even more popular alternative than the medical sects was the use of patent medicines. They were promoted, readily available, relatively cheap, and self-prescribed. By the 1870s there were thousands of these products competing for public consumption. Their manufacturers were not constrained by the necessity of rational, scientific medical explanations. They capitalized instead on people's desire for a magical cure. They advertised in the popular press and emphasized the horror of illness contrasted to extravagant testimonials of miraculous cures. They published popular annual almanacs to promote their products. To some extent they offered helpful advice for preventive care and hygienic practice, advice often neglected by regular physicians.

Patent medicines contained alcohol, cannabis, morphine and opium, which undoubtedly dulled the daily aches and pains for which people use Extra-Strength Tylenol or stronger tranquilizers today. The patents also contained various minerals and traditional herbs.

The regular profession as well as eclectics and homeopaths naturally fought the use of patent medicines, but no regulations were effective until the 20th-century. Patent medicine purveyors did a lively business in the newspapers and on the streets of San Francisco. They directed their appeals to specific diseases suffered there, such as tuberculosis, malaria, rheumatism, and syphilis. Certain patent medicine purveyors such as the "King of Pain" and Doctor Young, achieved quite a reputation for quackery in the city. Most patent ads deplored the use of harsh and dangerous



"regular" medicines, but many contained some of the same ingredients.

#### Endnotes Chapter Eleven

<sup>1</sup>A nostrum is "a medicine, or medical application, prepared by the person recommending it; esp. a quack remedy, a patent medicine" (Oxford English Dictionary).

<sup>2</sup>Arsenic was a common ingredient in patent medicines. It was used for all kinds of skin diseases, malaria, neuralgia, dyspepsia, and scrofula. John Haller suggests that the chronic dyspepsia among Victorians might have resulted from the use of Fowler's Solution containing arsenic (Haller 1981: 91-96).

<sup>3</sup>For more information on domestic medical guides see Fellman and Fellman 1981.

<sup>4</sup>As described earlier, Ayer's Ague cure contained "cinchona bark," "quinoi-dine," "sulphate of cinchona," sulphuric acid, sulphate of lime, sugar, and wintergreen oil.

## CHAPTER TWELVE:

## QUACKS AND CHARLATANS: THE PHYSICIANS' RESPONSE

Regular physicians in San Francisco complained through the 1870s about the presence of competing practitioners. Several arguments appeared consistently from 1869 to 1880: other arguments appeared only late in the decade. Debates between regulars and "irregulars" have revived in the 1980s, supplemented by the commentaries of sociologists, representatives of specific interest groups, health activists, and radical critics (Public Affairs Research Group 1981).

Most importantly, alternative practitioners in the 1870s were presented as "quacks"<sup>1</sup> and charlatans"; that is, it was assumed that their therapeutic approaches were a deliberate hoax. By labeling their competitors in this way regular practitioners were able to further legitimize their own position. Alternative practitioners were described throughout the decade as exploiting and fleecing the unsuspecting public. For example, in 1870 the Pacific Medical and Surgical Journal reported the story of a consumptive who had come specifically to San Francisco to consult a doctor who advertised cures. Friends had raised the money for this visit. The doctor demanded twenty dollars at the outset, made no examination; and proposed that it would cost five hundred dollars more. The patient recognized the doctor as an "imposter" and repaired to the office of a regular physician. This doctor found him to be in the last stage of tuberculosis. He commented that "No one other than a heartless and mandacious villain would have held out hopes of cure to this poor man and taken his money". He argued that the very itineracy and resort to advertising of such practitioners indicated their "knavery" (PMSJ May 1870 No. 36: 565-566).

In 1875 the same journal reported the case of Dr. Paul M. Brenan.

He advertised in San Francisco and later lectured in San Bernardino, presenting himself as a leading member of San Francisco's medical profession. He was exposed during a lecture when someone telegraphed to that city to ascertain his legitimacy. He promptly disappeared; but the journal commented that "people still persevere in running after every itinerant quack who proclaims his skill in the cure of disease" (PMSJ 1875 XVI(10): 501-502).

### The People Are Ignorant

Another argument consistently made against quacks was that they relied on the ignorance and credulity of the public. In 1869 an article circulated in the press entitled "The Plague of Quacks". Commenting that too few people objected to the astrologers, clairvoyants, healing mediums and "men of science who guarantee to cure all diseases for a 'consideration'", the editor concluded that charlatanism feeds on human credulity (California Medical Gazette April 1869: 172). The following year a newspaper editorial argued that "brazen humbuggerly exists everywhere". People would stop resorting to such practitioners as they became better educated, and as soon as the regular profession improved its own therapeutics. If the regular physicians stopped claiming infallibility, people would not turn to alternatives (Daily Alta California 1/7/1870: p. 2, c. 1).<sup>2</sup>

Also in 1870 a medical journal editorial complained that regular physicians were forced out of practice in the city because of the ignorance of the public: "never was there a place where so many desperate charlatans were pushing themselves upon unsuspecting invalids and thriving upon their fears". This writer blamed the regular profession in part for their "apathy and demoralization" about the problem (California Medical Gazette Feb. 1870 2: 126).

Toward the end of the decade similar arguments were made about medical ignorance. Dr. M. M. Chipman said in 1878 that most people understood little about anatomy, pathology, health and disease: or about the skill of physicians. He felt that public education in hygiene "would contribute eventually...towards evolving wise and efficient sanitary regulation, the suppression of the peculiar American evil and imposture of quackery, and the better development, improved healthfulness, and increased longevity of the human family" (Chipman 1878: 206).

In spite of such urgings, a wealthy and respectable citizen was responsible for leading people to the healer, Mrs. Preater, that year. This man had been treated for years by homeopathy, which Dr. G. W. Graves felt accounted for his new belief: "for all physicians know that those who do not appreciate a learned profession are ready to drop one species of quackery and take up another at any time". Graves was especially disturbed that people of this class could be taken in "enough to believe that an ignorant old woman should be endowed with supernatural power" (PMSJ 1879 XXI(9): 395-397). A year earlier an editorial had commented on this same healer (Mrs. "Preston") that, "She has a moustache and a goatee, and in these probably lies her strength. It is the old story repeated. Thousands of such miraculous healers have appeared at different times and run their course for a season. They always find fools enough to feed on" (PMSJ 1878 XXI(7): 329-330).

#### The Doctors Are Blunderers

Many physicians recognized that the public preferred the less iatrogenic effects of alternative medical approaches (see Chapter Eight). But some physicians felt that it was a poor policy to expose any "errors" on their part. A local newspaper noted in 1870 that the regular physicians

attributed the popularity of charlatans to "the lack of confidence in the allopathic profession caused by the publication of the errors and follies of the past, and of contemporary physicians". The newspaper advocated such publication to help educate the public and improve their choices of physicians. The editorial suggested that the medical profession must improve its schools and its qualifications for practice, for "the science of medicine...is and has been full of blunders and blunderers". Regular physicians could learn even from alternative schools of thought (Daily Alta California 1/7/1870: p. 2, c. 1).

Agreeing with this criticism of the medical profession, Dr. Q. C. Smith wrote nine years later that people turned to quacks because lazy physicians did not keep up with their profession. This unqualified group,

when not visiting patients, spend their time sitting and loitering around places of public resort, telling and hearing puns and jokes, whittling splinters down to the little end of nothing, arguing politics and party measures, toying a fancy cane, and smoking long-nine cigars, and maybe, occasionally 'taking a smile,' lazily wasting their precious time in silly efforts to curry favor with the public (Smith 1879: 542-545).

Such physicians were clearly not conveying the proper professional and scientific image.

#### Only Quacks Advertise

Physicians objected strongly to medical advertising in newspapers. In 1873 an editorial in the medical press deplored physicians' advertising with private cards, handbills and public ads. It protested that some members of the San Francisco Medical Society were given credit in newspaper ads for various cures and operations. This practice was regarded as a violation of the Code of Medical Ethics (PMSJ 1873 VII(7): 360-361).

Henry Gibbons, Sr. wrote an editorial in 1874 discussing advertisements for patent medicines that enticed people, especially appealing to sexual problems. Reviewing the history of various patent medicines purveyors, Gibbons remarked that the quack must drum up business: "Pamphlets, almanacs, newspapers, distribute the infection. It requires but little knowledge of human nature to discover that reading of diseases causes persons to fancy themselves sick, and sometimes even makes them sick". Gibbons presented the typical scenario:

In this city...there are...hundreds if not thousands of men, who have been startled from their daily labors in the mines and fields and work-shops by reading the well-devised, sensational advertisements which pollute the columns of almost every newspaper. Gathering up their hard earnings, they hie them away to the city and rush into the trap. Their fears are realized; their apprehensions are promoted, and a cure is guaranteed for a fee in advance. Once in the toils, their course is onward and downward, forever (Gibbons 1874: 10).

Gibbons himself knew how to use language persuasively. Here he presented as frightening an account of the perils of going to quacks as did the quacks of the perils of disease. He also suggested that the city's high rates of both unemployment and syphilis were somehow attributable to quack advertising!

Also in 1874 Dr. R. W. Murphy published an article criticising the use of patent medicines. He described the ways in which they were advertised:

The numerous traveling agents that overrun our land, painting their advertisements on every house, fence and board; posting handbills on every corner and sending them thousands of miles through the Post-office; distributing them in families, publishing sworn certificates, purchased for a paltry sum, in pamphlet form, accompanied, perhaps, with the calendar for the year (all of which is graciously given away); columns of advertisements in our daily and weekly newspapers, offering specific cures for any and every disease (Murphy 1874: 590).

He recommended legislation to control these medicines. But he warned that it would be a difficult fight because the patent manufacturers "have thousands of subsidized newspapers to sustain them" (Murphy 1874; 595-596).

In 1879 the Pacific Medical and Surgical Journal again called the attention of physicians to their Code of Medical Ethics, as they had in 1873.<sup>3</sup> By this time the medical profession had begun to blame the apothecaries, druggists or pharmacists for the promotion of quack advertising. Henry Gibbons, Sr. had commented in 1874 that "apothecaries sometimes prostitute their office and beget nostrums". They themselves became "nostrum-mongers", using knowledge acquired in their pharmacies (Gibbons 1874: 2). Dr. Murphy commented that year that patent medicines accounted for two-thirds of druggists' sales (Murphy 1874: 592-593).

What was worse was when quack advertising appeared in medical journals themselves, and in other professional journals. This practice was also blamed on the pharmacists. In fact pharmacists' ads provided most of the revenue on which these journals relied. But Henry Gibbons, Sr. found in 1878 that the ads were "impregnated, if not saturated, with quackery....Even proprietary remedies and secret nostrums are allowed to thrust their brazen fronts into the journals". He gave examples of such ads and called upon the pharmaceutical organizations to clean up their act. He remarked that their job was to prepare medicines, not to prescribe them (Gibbons 1878c).

The pharmacists had responded to such criticism in 1874 that the physicians were responsible for this problem because they were the prescribers. And many physicians provided certificates of merit to patent medicines ("puffs"). The regular profession responded that the pharmacists should put their own house in order before they criticized others (PMSJ

1874 XVI(5): 254-257). Thus accusations and counter-accusations were exchanged.

In 1875 a religious journal deplored patent medicine advertising in other such journals. The Rev. Stephen H. Tyng commented that such medicines might be all right in "uncivilized countries" like Africa and "Feejee" where native doctors might be a worse evil than the patents, or in rural areas where doctors were often incompetent. But where educated physicians were available, such advertising was to be condemned (PMSJ 1875 XVIII(3): 145-147).

Several druggists endorsed a nostrum in 1880 in an ad that specifically advised people not to go to a doctor. The medical profession was naturally angry about this, especially since they sent prescriptions to be filled by the same druggists. The object of physicians' attacks clearly shifted by the end of the decade from the newspapers to the pharmacists:

We say nothing of the newspapers selling their columns to quacks and impostors. This is their business, and people expect nothing better. But have we not a right to look for better conduct from druggists, who know more of the nature of the business, and who directly father the charlatanry and imposition? (PMSJ 1880 XXII(8): 374-375).

#### The Mask of Deception and the Healing Power of Nature

Early in the decade an argument was made that appeared thereafter. It was that medical cults used ingredients from regular medicines, and therefore contradicted themselves. For example, in 1869 an editorial asked, "What is Eclecticism?" It quoted Dr. Scudder's rejection of heroic approaches in favor of "'those that act kindly and pleasantly, and increase vital power'". But the editorial triumphantly revealed that Professor Scudder's "direct sedative" contained *veratrum viride* and



aconite, which were regarded as depressants of vital power (PMSJ Nov. 1869 No. 30: 278).

By these arguments the eclectics not only used contradictory ingredients, but they also relied on regular medicine without acknowledging it. In 1870 an editorial in the medical press commented sarcastically: "In nothing do the eclectic journalists show so good judgment as in choosing materials for their journals from among the writings of the regular schools which they denounce" (PMSJ May 1870 No. 36; 569). Again in 1874 the same journal complained that the eclectic Medical Times copied many pages from "the 'blood and murder' periodicals of the 'regulars' whom they abhor, and not a solitary line from a journal of their own faith!" (PMSJ 1874 XVI(2): 104). The eclectics would not deny however, that they used some regular medicines. It was part of their eclecticism (see Chapter Ten).

The idea that alternative medicines were successful because they secretly used regular ingredients was counterpointed by the argument that they succeeded because most diseases have a natural course. Dr. A. B. Nixon said in 1872 that "The apparent success of homeopathic treatment of disease can only be attributed to the influence of nature in disease and hygiene-- the infinitesimal doses of medicine being the veriest myth and delusion" (PMSJ April 1873: 532). The Daily Alta California newspaper agreed in an editorial that "A large part of the success of charlatans is due to the fact that they prescribe harmless stuff and their patients recover by the healing power of nature". If regular physicians used their strong medicines only for severe cases, more of those who were only "slightly affected" would recover more quickly (Daily Alta California 1/7/1870: p. 2, c. 1).

Several regular physicians who favored Conservative Medicine were exceptionally honest about these realities. Dr. F. W. Hatch for example, argued that "all intelligent physicians will testify" that two-thirds to three-fourths of their cases "would, sooner or later, and with more or less inconvenience and difficulty, recover without medicine". He advocated diet, rest and hygiene (Medical Society of the State of California, Transactions...1872 and 1873: 102).

Rivalry with alternative medical systems became hostile and even irrational at times. A key point raised again and again during this decade by members of the regular profession was over the term "allopath" applied to them by homeopaths. For example in 1873 physicians asked that people not be misled by this term into believing that regular practitioners were sectarian. They blamed eclectics and others for,

attempting to terrify the uninformed with an ugly sounding name like the man who mortally insulted another by calling him a 'quadrangular parallelogram.' The design of this cry of Allopath is to play on the ignorance and prejudices of the people, and to make the impression that...almost the entire medical world, are murderous sectaries (PMSJ 1873 VII(3): 151-152).

The regular medical profession claimed that it differed from sectarians not only in medical training, but also in that regular physicians were not exclusive or dogmatically constrained by a single medical theory (see Coulter 1973: 140-236). The well-known public health physician, Dr. F. W. Hatch, stressed in 1873 that legitimate medicine was a cumulative, progressive, nondogmatic science, unlike hydropathy, homeopathy, and Thomsonianism. He urged that the term allopath not be used, because it implied that regular doctors were inflexible in their approaches. He also argued that patients of alternative practitioners often recovered simply because of the self-limited nature of most diseases. Dismissing

alternatives as fashionable "medical novelties", he stated that they consisted of methods only, and were not medical systems. They rested "upon an exclusive dogma...narrowed down to a single idea, from which, if there be a momentary departure, the vitality of the thing is lost". Regular medicine however, was not exclusive (Hatch 1873: 98).<sup>4</sup>

Rather, the regular physician was empirical in his approach, using what worked, often not knowing and not caring why, as in the case of quinine. Hatch also strongly advised against "roaming about after different medical advisers in every new case of sickness, or even in the same case" (Hatch 1873: 99-100). In spite of general advice to the contrary, many physicians still prefer such paternalism today.

The argument against the term allopath continued through the decade. In 1876 physicians argued that they were not dogmatic in the administration of medicines, as the term implied. They availed "themselves of all the light to be derived from physiology, pathology, chemistry, and the collateral sciences" (PMSJ 1876 XXII(1): 34). In 1878 the regulars stated, "Let us claim for our profession an unlimited and universal scope, designated by such terms as 'regular' or 'rational,' dissociating it from all exclusive dogmas, all narrow 'pathies' and 'isms'" (PMSJ 1878 XXI(1): 26).

#### The "Eclectic Church" and the "Preposterous Pharmacy"

Criticism of other medical practices became focused by the end of the decade on the two most threatening to regular medicine, the homeopaths and the eclectics.<sup>5</sup> The Pacific Medical and Surgical Journal had printed numerous short, sarcastic pieces making fun of these two groups (e.g., Nov. 1869, No. 30: 278; Sept. 1870, No. 40: 183; 1872 VI(1): 49-50). At the same time, it similarly scoffed at other alternative practices (e.g.,

Nov. 1871, No. 54: 275; March 1872, No. 58: 477). By mid-decade however, sarcasm began to be accompanied by more serious criticism, as the two alternative schools became more popular. The journal suggested that there had been a "change of base in homeopathy" in 1873, with greater recognition of morbid anatomy. The homeopaths, according to the regulars, were now aware that different forms of "exudation" in a disease might produce similar symptoms, but require different treatments (PMSJ 1873 VII(4): 199-200). But in the next year this cautious praise was replaced by the usual carping about homeopathy (PMSJ 1874 XVI(7): 350).

In 1875 formation of the Eclectic State Medical Society was announced in this journal. The editors again complained that their approach was too exclusive and led to quarreling among adherents, who then often left the "Eclectic Church" and entered the regular profession. This was faint praise for the eclecticists over the homeopaths, whose "preposterous pharmacy" was not amenable to translation into regular medicine. It was necessary for a homeopathic practitioner to "be born again before he can enter the ranks of rational treatment" (PMSJ 1875 SVI(8): 402-403).

Again poking fun at homeopaths in 1876, an editorial reported that a homeopathic doctor sought advice from his colleagues to recover from a fall from a horse. He reported that he had tried numerous remedies both "high" and "low" (referring to dosage level). The editorial suggested "a remedy on the principle of similia similibus. Take a strong bottle filled with water and let it fall from a horse as nearly as possible in the way you yourself fell. Take one drop of the water thus medicated, potentize it low, and smell it. If that should not cure you, try it high" (PMSJ 1876 XIX(4): 169).

Patent medicine purveyors did not improve the regulars' estimation

of homeopaths and eclectics by adopting their logos. In 1877 "a brace of quacks in the interior" called themselves "Homeopathic, Allopathic, and Eclectic Physicians and Surgeons". They advertised treatment for Liver Complaint, giving, according to the critics, "a train of symptoms with one or more of which half the people of the world will find themselves afflicted" (PMSJ 1877 XIX(8): 360).

That year the regulars seized upon a specific, potent argument against both homeopaths and eclectics: their opposition to smallpox vaccination, "this greatest gift of medicine". For example, an eclectic doctor addressing one of his own medical societies called vaccination "the most absurd and pernicious" of all medical fallacies (PMSJ 1877 XX(1): 43)

Arguments against these two medical alternatives reduced by the end of the decade to one essential criticism of each. Eclectics were regarded as really little different from regular practitioners who were also open-minded enough to use a variety of medicines. Many of them were seen as abandoning their sect and joining regular medicine (PMSJ 1880 XXII(12): 572). Homeopaths were considered to be more hostile to the regular profession, probably because they were a much greater competitive threat. So the regulars argued that again they did not object to homeopathic remedies when they were appropriate: "Liberty to use what we want is what distinguishes regulars from sects, which are dogmatic" (PMSJ 1879 XXII(1): 20-22). A regular doctor would use the doctrine of similia: "when vomiting may be relieved by an emetic or diarrhea by a cathartic". But they did object to the use of infinitesimals (PMSJ 1879 XXII(1): 21-22).

The Medical Law

Desire to increase control over irregular practitioners brought about calls for legislation to license the medical profession. In 1875 Thomas Logan, Permanent Secretary of the State Board of Health, drafted such an act for the legislature. He said that it was necessary to act against the "terrible evil" of "unrestricted quackery which now sits like a vampire upon the body politic, and which is never satisfied until the last drop of the blood of its victim is exhausted" (State Board of Health, Third Biennial Report...1874 and 1875: 6). Anticipating his critics, Logan stated that the public did not understand that such a law was meant to protect them, and was not self-serving. As revised and approved, Logan's proposal was entitled, "An Act for the Better Protection of the Sanitary Interests of the People Against Fraud and Imposture in the Practice of Medicine and Surgery" (State Board of Health, Third Biennial Report...1874 and 1875: 233-234).

As approved by the legislature in 1876, the law was termed, "An Act to Regulate the Practice of Medicine in the State of California". The law required that a person had to be certified either by presenting a genuine diploma as a graduate in medicine,<sup>6</sup> or by passing an examination. Each State Medical Society was to appoint annually a seven-member Board of Examiners to issue the certificates. Practitioners without genuine diplomas could no longer be examined and certified after December 31, 1876. The Boards could refuse certificates and revoke them on the grounds of unprofessional conduct. Patent medicine purveyors were controlled by requirement of a one hundred dollar a month license from "Any itinerant vendor of any drug, nostrum, ointment, or appliance of any kind, intended for the treatment of disease or injury" (PMSJ 1876 XVIII(11):

524). Fines were stipulated between fifty and five hundred dollars for illegal medical practice, or thirty days to a year in prison (PMSJ 1876 XVIII(11): 521-524). This law would have effectively given control over medicine to the regular profession if it had been fully enforced. But it was not (Dunlop 1965: 5).<sup>7</sup>

The immediate criticism of the law in San Francisco was that each State Medical Society was permitted a Board of Examiners. Thus the Homeopathic and Eclectic Medical Societies were allowed to legitimise the practice of their adherents. The major San Francisco medical journal commented that the homeopaths immediately went out and organized a second society for themselves so that there would be two in the state (PMSJ 1876 XVIII(12): 586).

Debate about the new medical law continued through the end of the decade. In 1878 S. P. Crawford of Dixon, California asked how unprofessional conduct was to be defined. In his opinion homeopaths and eclectics "advertise...insure cures for a stated sum...sink the reputation of a professional brother, catch cases by hook or crook to make money out of them". The editors of the Pacific Medical and Surgical Journal responded that each of the three Boards of Examiners had its own code of ethics. If all conformed to the same code, homeopaths and eclectics would have the same status as regulars. That possibility was to be avoided. Instead the law was meant to segregate these practitioners from regular practice (PMSJ 1878 XXI(2): 64).

The same editors, responding to criticism, denied that the law was motivated by a desire to protect the regular profession from rivalry:

It was moved by the same humane impulse which prompts the extended movements all over the world in favor of hygienic and preventive medicine. Physicians are not to be benefited personally through the culture and operation of what

has been called sanitary science. On the contrary, they cut off their own supplies by sapping the fountains of disease (PMSJ 1878 XXI(1): 26-28).

The fact that the text of the medical law made no provision at all concerning sanitation did not deter these editors from identifying regulation of medical practice with the popular sanitary movement. Laws of hygiene and laws controlling the practice of medicine were somehow analogous by this argument.

In 1880 the battle continued when a Dr. Breyfogle, a homeopath who had graduated from a regular medical college, was appointed to the California State Board of Health. The regulars complained that homeopaths were not concerned about public health. An editorial argued that "The great principles of hygiene and State medicine as established by the regular profession, can not be controverted" (PMSJ 1880 XXII(9): 414-417). The fact that many homeopaths opposed vaccination was presented as a particular danger. But that alternative practitioners were much earlier advocates of hygienic and preventive health measures than were the regulars was not mentioned.

That an eclectic practitioner was found to be on the State Board of Health was not regarded as troublesome, since eclectics were similar to regular physicians, and "less clannish and less aggressive than the homeopaths; and they have more common sense". Eclectics were believed to be soon absorbed in the regular profession, even though the examining boards of both sects were thought to have licensed "some of the most notorious quacks in California" (PMSJ 1880 XXII(9): 414-417). According to the Medical Directory of the Pacific Coast in 1880 one in eighteen regular physicians was licensed on examination without diplomas, one in five homeopaths (18) and one-fourth of the eclectics in the state (49) (PMSJ



1880 XXIII(5): 221).<sup>8</sup>

Summary Chapter Twelve

The more general arguments against alternative medical practitioners in the 1870s were that first of all, they were charlatans. They relied on the ignorance of the public which did not understand medical matters. It was argued that people also avoided physicians because they used heroic measures, had made errors which were publicized, and were lazy and did not keep up a professional image. The medical regulars also objected strenuously to the advertising of alternative practitioners and patent medicine manufacturers. Finally they blamed their professional colleagues, the pharmacists, for promoting, advertising and selling alternative medicines. In addition to these general criticisms, more specific complaints were directed at homeopaths and eclectics.

Regular physicians complained that the term allopath applied to them by homeopaths relegated them to the status of sect as well. They wisely asserted that theirs was the "regular" or "rational" approach to medicine, with none of the dogmatic taint of a sect. The regular profession used several arguments to prove their legitimacy over competitors. They claimed that eclectics and homeopaths actually used regular medicines to effect their cures under the guise of phony theories and methods. Finally the regular physicians were able to pass a law regulating the practice of medicine in the state, although they had to admit their chief rivals, eclectics and homeopaths, into licensed practice as well. Although it was rarely enforced, this law served to outlaw all other alternative medical practices, such as those I shall discuss in

Part Four. The medical law was defended by its proponents through an identification with the growing sanitary reform movement, in spite of the fact that it made no statement on the subject. Nevertheless, the regular profession benefitted from the symbolic power of this law, which both identified illegitimate practitioners and associated regular physicians with the success of the public health movement.

#### Endnotes Chapter Twelve

<sup>1</sup>This term may have originated in England with the Quake Doctors who treated malaria's shivers and quakings (Maple 1968: 42).

<sup>2</sup>Many somewhat unorthodox physicians argue similarly today: "If more doctors really were experts with respect to nutrition and heredity, they would be able to give their patients sufficiently intelligent advice so that quackery and faddism could have very little scope. A depressing aspect of the situation is that the layman's intuitions, uninformed as they may be, are more often justified than the physician's neglect" (Williams 1971: 16).

<sup>3</sup>"It is derogatory to the dignity of the profession to resort to public advertisements, or private cards, or handbills, inviting the attention of individuals affected with particular diseases--publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints, or suffer such publications to be made; to invite laymen to be present at operations, to boast of cures and remedies, to aduce certificates of skill and success, or to perform any similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician" (PMSJ 1879 XXII(5): 227-228).

It is interesting that only recently, in the 1970s, have some physicians and dentists begun to advertise their practices in newspapers.

<sup>4</sup>This is a typical example of confused usage of such terms as theory,

system, and method. The irregulars were accused both of relying too exclusively on theory and too exclusively on method.

<sup>5</sup>There were criticisms of other sectarian approaches, such as hydrotherapy, which was never as popular in the United States as in Europe. In 1872 it was reported in San Francisco that sixty patients with ileo-typhoid fever were given cold water treatment in Vienna. The result was that 28 per cent died, compared to 27 per cent deaths among those not so treated (PMSJ March 1872 No. 58: 477). An effort to use controlled samples to compare therapies had begun. In 1878 hydrotherapy was explained to the San Francisco medical profession; i.e., fever, or heat, was to be treated with cold water (see Part Three). By this time, it was reported, the treatment was losing its primarily German advocates (PMSJ 1878 XXI(1): 32). By 1879 hospitals in Vienna and Paris had ceased using it and it was felt that mortality in Germany had actually increased from cold water baths (PMSJ 1879 XXII(6): 287-288).

<sup>6</sup>The urgency of such legislation was in part motivated by lax standards in the medical education of regular physicians themselves, often graduates of a year or two training in a "diploma mill".

<sup>7</sup>Today California has the second largest medical regulatory board (The Board of Medical Quality Assurance) in the country, with nineteen members, seven of whom are not physicians. The state also regulates 25 allied health care occupations. It is currently a misdemeanor to treat the sick or afflicted without a valid license or certificate. Physicians are required to attend medical school after at least two years of college, and to do a year's hospital internship and pass a Board exam.

<sup>8</sup>"As late as 1910 one-quarter of California's 4,500 physicians still divided their allegiance between eclecticism and homeopathy" (Muscatine 1975. 244).

## PART FOUR: THE FOLK RESPONSE AND CLIMATOTHERAPY

## CHAPTER THIRTEEN: OLD LADIES, QUACKS, AND HOME REMEDIES

Medical anthropologists have conceptually distinguished the act of "curing" from that of "healing", in connection with the distinction between disease as a biomedical phenomenon and illness as a larger cultural complex. Practitioners attempt to cure disease and to heal illness. Healing addresses a social experience involving more than physiological symptoms. Insofar as healing does not affect key features of this cultural complex, it fails, whether or not disease has been cured. The cultural meaningfulness of being ill in a certain social setting has its own explanatory model which the successful practitioner understands. Healing serves to give meaning to this model to patients who rarely make an analytic distinction between disease in the biomedical sense and its sociocultural context.

From this perspective it is easier to understand the success of various healers, shamans, "witch-doctors", and modern wholistic therapists cross-culturally and historically. Two important explanatory features of the success of healers lie in the nature of the doctor-patient relationship and in the nature of the diseases presented. The mere presence of the doctor or healer and his or her ritual accouterments may have a healing effect. The role played by magical beliefs in this process was mentioned in Chapter Eleven. Expectation of treatment and relief from receiving it may also psychologically produce alleviation of physical symptoms. Current social science literature discusses the doctor-patient relationship largely in terms of its psychodynamics and the problems that occur in verbal communication (Szasz and Hollender 1956; Pratt, Seligmann

and Reader 1957; Ostwald 1968; Korsch and Negrete 1972; Pouillon 1972; McKinlay 1975). But only a few have followed Malinowski's (1948) identification of the importance of ritual in the interaction between patient and healer in Western society. The culturally-prescribed ritual of the performance is the decisive feature of healing. Without that context, any treatment, whether socially legitimated or not, is likely to be ineffective (except for the specific effects of drugs or surgery). The healer is a magician and engages in potent ritual, whether in the guise of science or magic. What is of special importance to the effectiveness of treatment is the trust and confidence placed in the healer and the likelihood that associated psychosocial concerns will be confided (Lévi-Strauss 1967: 161-180; Middleton 1967; Emerson 1970; Hand 1976: 5; Eisenberg 1977: 236-237; Kleinman and Sung 1979; Kleinman 1980; Taussig 1980; Rappaport and Rappaport 1981).

Beyond the powerful effect of providing meaning and reassurance, the healer is aided in his effectiveness by the nature of most diseases. Patients usually present acute, self-limited diseases, non-life-threatening diseases, and somatized psychological problems. In these cases psychosocial and cultural treatment, usually defined by prescribed rituals, play a greater role than attempts to cure disease. The pragmatic approach of most people cross-culturally leads them to distinguish types of illnesses appropriate for types of healers. Thus it is common for people to take acute conditions to burgeoning Western scientific practice newly introduced to their societies, and other illnesses to their indigenous healers (Erasmus 1952; Paul 1955; Gould 1957; Foster 1962; Kleinman and Sung 1979; Young 1982).

These features of the healing process are universal and existed in

19th-century America. Most of the diseases presented to physicians or healers or treated at home were self-limited, chronic, or beyond current curative abilities. Physicians themselves recognized the self-limited nature of many infectious diseases (Chapter Eight). The belief that the 19th-century "family doctor" was more caring and healing in his approaches than present-day physicians may be largely a myth. From what we know of heroic treatment and the immense popularity of alternative practitioners, it seems likely that many regular physicians were viewed as impersonal and mechanical, as they are today. Class differences in medical care meant that poor and ethnic immigrants rarely saw a "family doctor" unless he was one of their own. They attended dispensaries at best and ended up in public medical institutions at worst. Given that regular physicians could not cure infectious diseases anyway, it is not surprising that people were attracted to the healing powers of others.

At least one contemporary physician recognized the psychosocial nature of the doctor-patient interaction, and his ideas were reported in the San Francisco medical press in 1879. Dr. J. S. Hammond of Nevada wrote:

the average professional man finds his employment mainly in attending to minor ailments, working often by manner, by advice, and by soothing counsel, as well as by emetic, by cathartic, by forceps, and by scalpel. A physician should cultivate tenderness of manner toward the sick (Hammond 1879: 212).

Hammond felt that patients were especially sensitive to the doctor's attitude because of the excitable state of their nerves. He thus preferred a physiological to a magical or social explanation. He stressed that physicians must be gentler and more respectful towards their patients; for otherwise patients would resort to alternative healers (Hammond 1879: 215). Unless regular physicians inspired confidence in their patients,

they would lose them to such alternatives. A similar phenomenon may be observed today, as patients seek the gentler ministrations of wholistic health and alternative childbirth. It is often when dealing with conditions on the edge of medicine, such as childbirth, or in the cases of common or chronic ailments, that tender treatment is preferred to the harsh drugs and drastic surgeries of the regular profession.

By the end of the decade of the 1870s physicians were beginning to appeal more and more to the charismatic authority of science to attract patients (see Chapter Six). In this they initiated a process that came to underlie the huge power of 20th-century scientific medicine. Patients need no longer share the medical ideology of their healers, for the ritual paraphernalia and practices of modern technology are overwhelming. Still, while this medicine may cure, it fails to heal. "Illness" remains more common than "disease"; but modern physicians are "trained to systematically ignore illness" (Kleinman and Sung 1979). In both centuries alternative healers have filled the sociocultural and economic gap between curing and healing.

In 19th-century New York City "midwives and 'old ladies'"<sup>1</sup> provided much medical care. Faced with infectious diseases, people turned to patent medicines, supplied by many pharmacists. There were also "pox doctors" who specialized in venereal diseases, herb doctors, and "electricians" who specialized in cancer and lung diseases. Among the regular profession competition was strong enough to enforce a model of home visits and family practice.<sup>2</sup> At least among the middle class, people had a personal relationship with their physicians (Rosenberg 1967: 226-231).

The working class and the masses of poor were treated at dispensaries, by visiting public health doctors, in hospitals, and by alterna-

tive practitioners, including ethnic immigrant doctors (Rosenberg 1967: 236-238). The suffering ill wanted medicines so physicians often prescribed placebos, believing them to be comforting if not therapeutic. But most of the drugs taken were patent medicines or home remedies.

"Granny" or midwife medicine was very much a part of western frontier life. Doctors with varying degrees of training also practiced. But often there were no physicians available.<sup>3</sup> Even in urban settings new immigrants often relied on their own resources rather than seeking help from a physician. Following the equilibrium model of health and disease, people emphasized preventive practices. When disease needed treating, people used home remedies usually made of common materials which were rubbed on, bathed in, eaten, or inhaled. Some of these remedies did bring relief and others received credit for the natural disappearance of self-limited diseases. Grannies knew some effective remedies. They used cheese mold on open sores (penicillin derives from mold); wet tea leaves on burns (tannic acid solution); flour and baking soda on rashes and bites; egg whites and cobwebs on burns and cuts; kerosene and turpentine, which are disinfectants. Whether effective or not by today's standards, most folk medicines were as effective and less expensive than patent medicines or the heroics of regular physicians (Dunlop 1965; Japp 1982).

Because of the frontier nature of western American life, alternative practitioners survived professionally later into the 19th-century than they had in Europe and England. The American value of free enterprise also helped them to persist. By the 20th-century southern California in particular became a center for the popular sectarian health movement. Health resorts flourished there and in the Southwest for tuber-



culosis sufferers and others (Baur 1952, 1959; Jones 1967; Maple 1968).

The presence of various sorts of healers and curers in 1870s San Francisco is apparent in both the newspaper and medical presses. Some healers focused on "the sexual apparatus" and appealed to sufferers from "seminal weakness" and venereal diseases. The anatomical museums that existed earlier in San Francisco frightened such sufferers with grisly displays (Gibbons 1874: 10-13). There were bone-setters in San Francisco who exhibited an inherited gift to manipulate the joints and spine. There were also "worm doctors" who treated people for supposed or real internal parasites (Gibbons 1874: 5-7, 9; see also Smith 1979). Various clairvoyants, astrologers and soothsayers became quite popular in the city towards the end of the 1870s, in response to anxiety about the financial stability of the community.

In 1869 the medical press ridiculed "botanic doctors" by publishing a letter from one Priddy Meeks of Oregon. He wrote Henry Gibbons, Sr. about his practice. Whether or not this letter is authentic, it gives a sense of how such curers worked:

I am entirely anti Poison in my practice I neither Bleed, Blister nor starve the patient, I call on the vegetable kingdom for my medicines which the great creator has profusely placed in the Earth on purpose for the healing of the nations, My practice cures every complaint incident to the human family if there is life Enough in the system to build on even the dyspepsia & consumption which I cure readily since I have got to understand it which knowledge is original with my self which is the result of sixteen years experience on dissecting and clinical observations having formed a new theory entirely on consumption and applies my Medications accordingly....one man came from Illinois to utah to me to be cured of the dropsy I took all the water out in a week without Tapping, I never tap, I gave him medicines by the mouth only A knowledge of a great many remedies was derived from the Indians & a great many remedies is original with myself I am now nearly seventy four years old & nearly half that time has been spent for the Benefit of suffering humanity (PMSJ 1869 3: 72-73).

Gibbons responded sarcastically to this letter that if Priddy Meeks came to San Francisco, "we guarantee him an ample practice, with merchants and possibly clergymen for patrons, after the style of Li-po-tai, the Asiatic mountebank" (of whom more shortly) (PMSJ July 1869 3: 73). In 1871 the same journal reported that

A celebrated quack, known as 'Indian Joe,' was lately stoned to death by his stupid brethren of the Piute tribe, in Inyo County, because he failed to redeem his promise to cure two sick Indians. He should have been sent to San Francisco, where he could have made a fortune by practising on gentlemen and ladies of white blood, as a partner of Li-po-tai or Darrin (PMSJ Nov. 1871 No. 54: 275).

"Old Lady" medicine occasionally reached the city. In 1878 and 1879 there was discussion in the medical press about Mrs. Preater (or Preston) who practiced on "top of the mountains" near Cloverdale in Sonoma County to the north. Local residents of the town of Petaluma were her clients. Claiming the ability to "see through" her patients, this granny cured blindness, cancer and other afflictions. She removed lizards, snakes, worms, and something she called "water dogs" from people's stomachs with a dissolving medicine. Her remedy was described by a local doctor as a "cheap wine, which she puts some bitter drugs in and sells... generally prescribing no less than five gallons at once". She also encouraged people to apply paint to the scalp for catarrh and other parts of the body for other ailments, "to cause the disease to 'run out through the skin'". An observer reported that the "paint" was a "powerful vesicant, and produces terrible sores". This woman was apparently a legitimate curer, having suddenly acquired her calling through a mystical experience:<sup>4</sup>

several years ago, while in a room with a friend, she became suddenly blind, and...when her eyes were opened, she saw mysterious writings on the wall, commanding her to be kind to the sick, and...ever since then she can

'see through' any one as easily as if they were made of clear glass (PMSJ 1879 XXI(9); 395-397).

The popularity of this healer spread far and wide. Richard G. Stanwood, a businessman who lived in a town northeast of San Francisco wrote his sister in October 1879 that some neighbors had sought her cures:

They made a pilgrimage to Cloverdale to see a celebrated doctress, who not only told them all just what ailed them, but also what ailed Mr. Cumberson whom she hadn't seen. She has performed many wonderful cures, and her medicine, it is said, effects its object, in nearly every case, by bringing out a quantity of sores all over the body, something in the nature of boils (Stanwood 1852-1884: 10/15/1879).

The last comment may have been in way of a joke for his sister who was continually plagued by boils.

In 1879 it was reported that the healer's popularity was fading; but she had enjoyed a large enough clientele to threaten the city with the rumor that "the most celebrated physicians of San Francisco are in the habit of sending their obscure cases to her, that she may 'see through' them and report the diagnoses" (PMSJ 1879 XXI(9): 395-397; PMSJ 1878 XXI (7): 329-330).

#### Clairvoyance, Mind Cure and Blue Glass

The popularity of clairvoyance and fortune telling, spiritualism, mind cure, and associated phenomena goes a little astray from the scope of this work. But it all quite clearly occurred in response to economic anxiety. People today also retreat into the personal as they are faced by overwhelming societal problems and economic pressures. In the late 19th-century "Mind cure was a acknowledgment that the link between individual and social perfection was, if not broken, at least decidedly weakened" (Fellman and Fellman 1981: 36).

Clairvoyance offered a means of survival for unemployed single

women in 19th-century San Francisco. Harriet Lane Levy relates the story of her childhood neighbor Mabel Lessing, who, widowed at 30, became Mme. Sybilla, receiving clients in her parents' home. Mrs. Levy comments, "we grew to respect the woman who had met the exigencies of widowhood in so original a fashion and had established herself independent of her parents" (Levy 1975: 47, orig. pub. 1937). Women today in San Francisco similarly establish themselves as wholistic nutrition consultants, masseuses, hypnotists, acupuncturists, and so on.<sup>5</sup>

Advertisements in the San Francisco press suggest the diversity of curers available in the 1870s:

Mrs. Ada Pierce, Trans-Spirit Medium; sittings daily; circles Thursday and Sunday evenings. 282 Sixth st.

Mrs. Grey, the Celebrated Clairvoyant, Healing and Test Medium, Thousands attest her skill. 366 Mason st.

Mrs. H. Roberts, Ladies' Physician, 1431 Mission st.

Feistel & Gerrard, Chiropodists.--Treat skillfully corns, bunions, toe nails, etc. 836 Market street.

Mme Regal Cures Diseases that have been pronounced incurable; references given; consultation free. 776 Edward st.

Roots, Herbs and Botanical Preparations, at Adams' Pharmacy, 111 Stockton street.

Doctress A. M. Hoffman, 1422 Folsom street...34 years experience; has her diploma of the highest school of Germany; will thoroughly treat all diseases of women and children.

Mme. Gottschalk, M. D. Late of Europe, so celebrated for her success in all complaints of married and single women.

Dr. W. K. Doherty's Medical and Surgical Institute...all Special Diseases Resulting from ignorance or folly.

(San Francisco Chronicle 1877).

Many of the ads appealed to the Unfortunate who had venereal diseases,

unwanted pregnancies, and sexual problems. There were usually whole columns devoted to spiritualists, mediums, and clairvoyants.

Mind cure was based on the notion that people might 'doctor themselves' without medicines by a metaphysical process (see Haller 1981). It was the precursor to Christian Science. Julia Root explained in the 1880s the popularity of this approach in San Francisco. She argued that disease "is the result of a departure from the spiritual laws of God. Its true cause is not to be attributed to the presence, absence, or decay of any part or parts of the human system. These disarrangements are the effects and not the causes of disease". She recommended that all drugs be avoided, for faith in God was the only curative (Root 1884).

Nathan Boyd, an assistant editor of the Pacific Rural Press in San Francisco was a devotee of metaphysical healing. He and his wife attended nearly daily meetings on mind cure in the 1880s, and he attempted some healing himself. At one time he suffered from "an acute catarrh - which began yesterday - made my head a fountain of tears". He soaked his feet in "hot mustardized water, & went early to bed, with a pint of hot lemonade for dinner". When his "cold" continued the next day he "dropt in at Mrs. Elder's & she gave me a friendly 'treatment' - metaphysical - which appeared immediately helpful". He had another treatment the next day. By the next year Boyd himself was giving metaphysical treatments to a jaundiced San Francisco gentleman (Boyd 1886, 1887).

The visiting Guillermo Prieto, who described San Franciscan life so colorfully in the 1870s, commented on various practitioners he observed:

a word might be said of gypsy fortune-tellers, spiritualists, and others who reap without sowing in this rich country. Among the clairvoyants, mention must be made of Doctor Koern....He has a large clientele and receives like a potentate. People say he has accumulated a sizeable fortune....The

peculiar superstition of Americans is best revealed, however, by the credence they give to the properties of 'blue glass'....In some towns of the United States the belief is prevalent that blue glass exercises so favorable an influence on health as to protect it from almost any conceivable ailment. To be sure, the antidote could not be simpler or cheaper. All that is necessary is to receive the solar rays through a bit of glass of any size whatsoever in any position. Victims of the imposture must be numberless, since there are in New York stores whose principal trade consists in the sale of blue glass as a talisman (Prieto 1938: 77-78; see also Daily Morning Call Jan. 22, 1877).<sup>6</sup>

Members of San Francisco high society became aware of blue glass treatment when they visited eastern cities. For example, Margaret Cameron Pierce wrote from Boston to her husband's sister in 1877;

Nettie also bought a square of blue glass, framed & with rings to hand by, and as I write she is basking in its chemical ray, 'reading it up', from a blue printed paper, extracts from Genl. Pleasantons book, The man, a painter on glass, from whom we bought it, says it cured him of a painful rheumatism in his right arm and he tried it without believing too (Pierce 1869-1888: 3/31/1877).

### "Chinese Barbarians"

There were both Black and Chinese doctors in San Francisco practicing within their own ethnic communities and among white clients. One of the well-known Black practitioners was Dr. Ezra Rothschild Johnson, "The Natural Physician and Great Pain Annihilator". He had his office on Washington Street, and conducted experiments with laughing gas for anesthesia in the mid 1860s (Parker and Abajian 1974: 4).

Chinese residents of the city had established health treatment through the Six Companies which oversaw their social and economic organization. In the 1860s associations based on place of origin in China each maintained a small "hospital" for members. This was "a facility usually consisting of little more than a few bare rooms furnished with straw mats". They

were allowed to operate because the city did not finance any medical services for the Chinese and largely excluded them from the public hospital. Medical care was provided by Chinese pharmacies and herbalists and traditional Chinese doctors, none of whom were licensed to practice in the state. Some Chinese merchants sought surgery, obstetrical or pediatric care from Caucasian physicians. But most Chinese were put off by "the language barriers, the higher fees, and strange medications and methods" (Trauner 1978: 81-82). Chinese healing became popular among white clients however, as one among many alternative approaches.

W. F. Rae, travelling from England in the early 1870s, commented on San Francisco's Chinese doctors:

These doctors are not afflicted with modesty as to the nature of their powers. At the entrance to an alley I saw a sign-board projecting from the side of the house, and intimating that 'Dr. Hung Ly cures all diseases upstairs.' In the newspapers these doctors advertise regularly. Thus may be seen among other announcements one to the effect that Dr. Jay Hon Chung, graduate of the highest medical college in China, has opened an office in Washington-street: -- 'The most obstinate and painful chronic diseases treated with entire success, and cures guaranteed'" (quoted in Lewis 1962: 173).

Another such doctor advertised in 1877: "Dr. Isun Yuen China Physician, cures all diseases, internal and external. 616½ California street" (San Francisco Chronicle Jan. 16, 1877 XXV(1): p. 1). The Langley city directory provided names of Chinese physicians each year. For example, it listed 15 names in 1871, 6 in 1873, 10 in 1874, 8 in 1875, 15 in 1876, and 10 in 1877. There were none listed in 1878 and 1879, probably because of an editorial change (Langley).

The most famous Chinese physician was Li-po-tai, because many members of the white upper classes were among his patients. He viewed the liver as the seat of medical problems, and treated them with herbal teas (Musca-

tine 1975: 240). The medical press quickly began to ridicule this competition. In 1869 it was reported that a woman with prolapsed uterus had been advised by him to shave the top of her head and blister it "for the purpose of drawing up the womb to its place". The editor sarcastically commented on the "superiority of Asiatic therapeutics" (PMSJ Nov. 1869 No. 30: 278).<sup>7</sup>

In 1870 the Daily Alta California went after Li-po-tai for "lining his nest". While other Chinese returned to China, he remained to make money off the "ten fools here for one he can find in China". Commenting that Li-po-tai had enough money to invest in city property, the editors related the death of one of his patients. The Chinese physician had advised the consumptive man that he must "be reduced" and then "built up";

The Caucasian belief is that consumption is more than sufficient for the reducing process, but the Mongolian M. D. knew better, and so for some weeks he labored assiduously, in conjunction with the disease, to reduce the patient. His treatment succeeded admirably in this respect. About the time that he had accomplished such a marked success in the physical reduction of the patient, however, the services of the undertaker were required, and the building up part never came into play at all" (Daily Alta California 1/2/1870: p. 1, c. 1).

It is a testimonial to the persuasive powers of ideology that the press was not similarly sarcastic about the ineffective treatments of regular doctors for this disease. Instead the paper commented that Li-po-tai's white patients "still crowd his rooms, fill his pockets and swallow his draughts, and he in consequence is enabled to feather his nest with valuable city real estate" (Daily Alta California 1/2/1870: p. 1, c. 1). Later in the decade his name was frequently invoked in comparison to some "quack" approach. For example, an English clergyman's cure for consumption, including snails, hartshorn shavings, and vipers, was attributed to Li-po-tai by the San Francisco press in 1871 (PMSJ Oct. 1871 No. 53: 228).



It is not surprising that one of the rare instances in which the Chinese were defended appeared in an eclectic publication. The Family Health Annual published a short piece entitled "Chinese Respect for Germs" in 1878. It commented that in most countries people pay no attention to the dangers of foul odors, but

The 'heathen Chinese' is much more rational in his conduct in this respect. Instead of ignoring foul smells and malarial and other similar causes of disease, he elevates them to the dignity of a god, whom he worships under the 'celestial' name of Fung-Shuy. To this deity he consecrates every locality where noxious odors and miasms are present. His own nose he takes as the interpreter of the will of Fung-Shuy; and when the latter admonishes him to avoid this spot or to vacate that, he obeys promptly, and so does not die of typhoid, typho-malarial, or bilious fever, as do his more civilized Christian brethren (The Family Health Annual 1878: 21).

This viewpoint certainly contrasts that of the San Francisco Health Officer, J. L. Meares, who that year was "rigorously condemning many of the pest pens yet over-crowded with coolies and reeking in filth" (San Francisco Chronicle 9/4/1878: p. 2, c. 3). Life in San Francisco was undoubtedly different for Chinese than it had been in their homeland.

In spite of the criticisms and acrimony displayed toward Chinese doctors, the public still sought their cures. James Manning Pierce wrote his sister in 1869 that a female cousin was improving under Li-po-tai's treatment. Referring to his wife, Pierce reported that the "celebrated Chinese physician...really cured Maggie of a very bad pain in the side which was very bad for about 2 years and baffled the most skilful M. Ds, in the city" (Pierce 1869-1888: 8/22/1869). As we know from reading further letters, Mrs. Pierce continued to suffer chronically from this mysterious pain, never diagnosed properly by Chinese or Caucasian doctors. James Galloway, who lived in various communities east of San Francisco during the 1870s, consulted Chinese physicians on several occasions. In 1869 he

wrote in his diary that his wife's breast was very sore after giving birth (she eventually died of breast cancer);

Nov. 10 1869 Did not much Emmas breast is getting very sore....Nov 12 1869 In the house and helped haul corn stalks went for Medicin from China doctor at night....  
Nov. 14 1869 In the house went for Medicin P. M. Emmas breast terrible sore....Nov. 15 1869 In the house had the Chines Doctor Cog Fy out. Emma suffered terribly this eve....Nov. 16 1869 Went to town Es breast broke this morn (Galloway 1853-1882).

In 1876 Galloway suffered from a bad cold for several weeks. He reported that he "got some Medicin from China doctor" (Galloway 1853-1882: 4/19/1876).

#### Home Remedies

It is important to realize that the majority of illness episodes in the 19th-century were treated at home, as they are today, without benefit of either professional or alternative medical consultation. It has been estimated that today as much as 70-90 per cent of illnesses are treated by alternative forms of health care (Kleinman, Eisenberg and Good 1978: 251). One physician today believes that folk medicine in the 19th-century may have been "objectively helpful" fifty per cent of the time (Gebhard 1976: 97). Millions of Americans still rely on it today (Hand 1976: 5). Empirical success must account for at least some of its staying power, in addition to the explanations offered earlier in the chapter.

Previous chapters have already discussed the professional class of physicians in San Francisco, sectarian alternatives, and patent medicines. In this chapter other healers and home remedies are discussed; and in the next chapter, climatotherapy. It has become clear that the variety of health care available to San Franciscans in the 1870s does not fit neatly into the conceptual categories of professional, popular, and folk discus-

sed in the Introduction. These analytic concepts present only the perspective of the researcher or historian (the etic perspective), not that of the participants (the emic perspective). Thus ethnomedicine fails in its own intention to investigate phenomenological experience. It is also flawed in not sufficiently recognizing class differences in treatment alternatives. Any one of these approaches might be used by middle and upper class San Franciscans; but the poor rarely or never saw private physicians.

In the face of illness and disease, indigenous, folk, or popular remedies develop in every society. Even where Western or regular medicine is the dominant model, people still distinguish between problems which can be handled at home, through an alternative healer, or through regular medicine. For example, Chinese residents of San Francisco sometimes sought Caucasian regular medicine for certain conditions, while using Chinese medicine for the rest of their health care. Erasmus (1977) has argued for the basic empiricism of such choices, and Gould (1957) has distinguished nonincapacitating dysfunctions treated by "village medicine" from incapacitating ones for which "doctor medicine" is sought. Often these choices must be seen as "derive(d) from opposed ethno-theoretical systems;" i.e., the popular viewpoint may be grounded in a social or moral etiology of disease, in conflict with "scientific" explanations (Romanucci-Ross 1977: 487).

Most people attempt to diagnose and treat any illness episode initially at home with over-the-counter or patent medicines. They then follow a culturally determined route of health advice and referrals, using a network of lay consultants including family, friends and respected acquaintances (Freidson 1960; Litman 1973, 1974; McKinlay 1973; Chrisman

1977). This process is not hierarchical, as it has sometimes been presented, from the simplest home remedy through increasingly sophisticated or complex therapeutic strategies. Rather it is a dynamic mixture of choices and actions with little or no regard for distinctions between professional, popular, or folk medical domains. We are forced by the nature of analysis to present the separate content of patent medicines, home remedies, sectarian practices, and so on. But in the mind of the patient the essential concern is with what works (Young 1976),

Nineteenth century San Franciscan medical practitioners were not unusual in the vehemency of their attack on alternative approaches. From the vantage point of modern medicine indigenous practices around the world have been regarded as annoying obstacles, or as actually productive of further spread or aggravation of disease. The role of folk measures in actually combatting disease is a subject of medical anthropological research (Foster and Anderson 1978: 223-262).

Nineteenth century Americans developed preventive and therapeutic approaches on their own against the recurring epidemics of infectious disease. Tar and pitch, sugar, vinegar and animal skins were burned indoors and out against the miasms of cholera. Gunpowder blasts were used to cleanse the atmosphere. Cayenne pepper, laudanum, calomel, wine and broth were used as remedies. People also avoided becoming overheated or chilled or eating or drinking in excess (Powell 1949; Rosenberg 1962; Pizer 1965; Duffy 1966, 1974; Baker 1968; Japp 1982).

Home medical guides were used widely around the country. They were written usually by physicians and were "standard equipment of most pioneer or pack trains". Two of the most popular were William Buchan's (1769) Domestic Medicine in continual reissues, and John C. Gunn's Domestic

Medicine, or Poor Man's Friend. Gunn's book emphasized simple rules of exercise, temperance, and cleanliness for good health (Brieger 1976: 34; Blake 1982; see Blake 1977 for a history of these books; and see Hechtlinger 1970 and Fellman and Fellman 1981). The books varied in the extent to which they were outside regular or professional medicine. Most suggested variations on standard heroic therapeutics. Some ignored such approaches and consisted of collections of household remedies. In 1869 George M. Beard published Our Home Physician, an example of the former type, in which people were urged to become knowledgeable about scientific medicine. Frederick A. Castle took this attitude a step further in 1880 with Wood's Household Practice of Medicine, Hygiene and Surgery. People were advised to treat themselves only in emergency situations.

During the 1870s and 1880s patent medicines increasingly substituted for traditional home remedies or kitchen medicines (Blake 1977). But people made syrups, soporifics, cathartics, emetics and abortifacients from numerous plants and herbs. Some medically effective drugs originated in this way: quinine, cocaine, ephedrine (used in asthma and hay fever), reserpine (used for hypertension), and mescaline (Ivey 1965: 161-162).

In the West contagion was warded off by asafetida or camphor or a live spider worn in a bag around the neck. Sliced onions in the bedroom or one in the pocket were believed effective. Numerous herbal concoctions were prepared, along Thomsonian lines (Dunlop 1965: 185-191; Jones 1967: 263). Early evidence of the kinds of home remedies people brought with them to the West is found in Amos Batchelder's diary and commonplace book. He came to San Francisco during the Gold Rush with the following among his medical prescriptions:

Phthisis Pulmonalis: Blood root, Annis seed, Liquorice Ext.,  
Gum Opium, Pure water

Cholera morbus: alcohol, lemon oil and sulph acid

Smallpox and Scarlet fever: sulph zinc, digitalis, sugar, water. "tsp every hour, cure in 12 hours"

Whooping cough: Bromid. ammon. tinct. Stramonium, water and syrup

Smallpox: "A medical man in California gives a curious prescription as a safeguard against Small pox when he says Place an ounce of cream of tartar in sixteen ounces of water and take a tablespoonful three times a day, and you may sleep with a small pox patient with perfect impunity. If every citizen would do this for fifteen days there would be an end to small pox in any city"

(Batchelder 1835-1849).

Suggestions were not much different in the 1870s. Western settlers often kept journals and scrapbooks that had home remedies in them. For example, the scrapbook kept by Mollie Watson Hill of Dayton, Oregon contained recipes for specific home remedies along with news items, poetry, family events, jokes and stories. Among the remedies for infectious diseases she recorded the following (often taken from newspapers);

A tea made of dried whortleberries, and drank in place of water, is a sure cure for a scrofulous difficulty, however bad

A tea made of willow leaves is a sure cure for fever and ague

A Sure Cure for Diphtheria - Diphtheria Wash. Golden seal, pulverized, 1 drachm; borax, pulv., 1 drachm; black pepper, pulv., 1 drachm; alum, pulv., 1 drachm; nitrate potash, pulv., 1 drachm; salt, pulv., 2 drachms. Boil in water, add vinegar, use as throat swab

Smallpox remedy - also cures scarlet fever - Sulphate of zinc, one grain; foxglove (digitalis), one grain; half a teaspoonful of water. Mix, add more water. Take one teaspoon an hour

Local application for erysipelas - acetate of lead, carbonate of magnesia, camphor, and water

Consumption. 4 pounds Malt, 2 oz Licwarish, 2 oz

Licwarish Root, 2 oz Puruvian Bark, 2 oz Barly Sugar,  
 1 oz Hops, 2 lbs crushed Sugar, 1 quart Best Brandy.  
 Dose wineglassful 3 or 4 times day<sup>8</sup>

In spite of these cures, Mrs. Hill's scrapbook reports the agonizing death of her only child as a baby, the death of her husband from gastric fever, the consumption of her mother, and the typhoid fever of several friends (Hill 1865-1885).

In San Francisco as elsewhere folk therapeutic responses to illness were typically an empirical, trial-and-error combination of herbal cures, patent medicines, doctor's prescriptions, home medical manual advice, and talismans. This eclectic mix is not surprising, given that regular physicians acknowledged their helplessness in the face of epidemics, and self-help was a valued part of 19th-century American "know-how" ideology. Early settlers in the Bay Area had to rely on self help. Helen D'Apery recalled that her mother was always called upon during illnesses in Oakland in the 1850s. There was no doctor available "until good, capable, blunt old Dr. Gibbons settled there" (D'Apery 1872: 405).

A popular home remedy was the use of mustard plasters or applications of red flannel. The eclectic Family Health Annual recommended this approach in the treatment of diphtheria in 1878. A sitz bath and blankets were to be used to cause perspiration; then the head and body sponged and hot and cold compresses of flannel cloths used alternately along with lemon juice on mouth sores and a vinegar and water gargle (Family Health Annual 1878: 28-29).

Margaret Pierce's husband wrote his sister during the first year of his marriage:

I am quite a physician now for Maggie has a sore throat for the last six weeks and have been using all sorts of remedies. Came nere burning her throat up night before last with a piece of flannel soaked in vinegar and red

pepper but I think it did her good. I miss her singing very much which has been strictly prohibited for the present (Pierce 1869-1888: 8/22/1869).

Years later Mrs. Pierce wrote of her child:

Elliott has not been very well for a week past & Dr. Burgess says he thinks he has had a mild form of it [scarlet fever], he had a little red rash on him... and complained of fleas & he had a sore throat so that I put a flannel & oil on, before sending him to school (Pierce 1869-1888: 12/14/1881).

Mrs. Pierce had had mustard applications many years before for her heart pains (Pierce 1868: 4/21/1868). In the 1880s Amelia Stein applied "hot cloths red flannel dipped in hops water" on her daughter Bertha's face when she had the mumps (Stein 1878-1884: 1/8/1886). James Galloway used a plaster on his sore back in 1871 (Galloway 1853-1882: 1/20/1871).

Richard Stanwood also reported the use of mustard plasters for several hours when his brother-in-law "had a pain" (Stanwood 1852-1884: 8/19/1878).

Hannah Ingalls participated when a dressing on the chest and mustard water were used for her brother's bilious attack:

Mrs. Bourn could think of nothing she could do but give him mustard water and I put a dress upon his chest and suggested an injection and she got one of the girls up and heated some water and he took it three different times and it had a wonderful effect. He was so exhausted he thought he should be able to sleep...but the difficulty was not removed for he was still in great distress, but vomiting relieved him for a time, then the pain was as severe as ever...Willie Bourn went for the doctor, he did not get here until nine. The doctor gave castor oil and he threw it up and a great deal of bile with it. He repeated the dose and after a time gave him pills and then powders...we hope the worst is over (Ingalls 1865-1866: 12/8/1865).

I do not know what the "injections" used in this case were. The doctor recommended another common home remedy, castor oil. Mrs. Stein often used it for her children. She also gave them "mustard baths" (Stein 1878-1884: 2/5/1881, 3/18/1884, 11/7/1884). Richard Stanwood's



daughter, Bessie, was given castor oil when she apparently swallowed a button (Stanwood 1852-1884: 4/22/1879). One of the remedies Mrs. Pierce took for her problems was cod liver oil: "were it not for my violent headaches, which the doctor is beginning to think are constitutional, I would be very well indeed. I am taking Cod-Liver-Oil & Port Wine three times a day, and hope to be quite fat & rosy when you come home" (Pierce 1869-1888: 3/9/1875). On another occasion Mrs. Pierce gave her son molasses vinegar and water for an early morning attack of croup (Pierce 1869-1888: 3/18/1877). Richard Stanwood's sister used cod liver oil when she "had taken cold" (Stanwood 1852-1884: 1/15/1879).

Herbs were used in a number of remedies. Mrs. Stein gave Gertrude some tea for her hives (Stein 1878-1884: 3/11/1884). Mrs. Pierce received "a nice little salt bag full of cat-nip" from her aunt. She gave her baby some in his bottle and "it broke his cold right away: it is so nice and green & fresh!" (Pierce 1869-1888: 12/18/1874). While visiting in Boston a few years later, Mrs. Pierce reported,

Frank and Minerva are as usual. Frank has had a severe attack of sore throat, which we almost feared might be diphtheria, which has been raging in Boston and Maine, in fact in New England almost as violently as in San Francisco -- but Minerva doctored him with herbs, and he remained indoors for several days; and though he coughs still, is better (Pierce 1869-1888: 3/18/1877).

Hannah Ingalls wrote her husband when she first arrived in San Francisco in 1865 that she took Thoroughwort tonic for a "most disagreeable sensation in my head", an ill effect of her voyage (Ingalls 1865-1866: 10/24/1865). Mrs. Joseph Newmark was faced with a four-week-old child with whooping cough in the early 1870s: "We gave him goat milk; he could not take the other. Then his whole lower body became so sore; it was pitiful, what the child suffered. I sat constantly by him, applied healing

salves, and burned senna; this soothed and did the child much good" (Newmark 1900: 9).<sup>9</sup>

When his son Eddie may have contracted whooping cough from a friend, and had been coughing for three months, Richard Stanwood cured him: "finally I dosed him with coltsfoot and flaxseed tea from a prescription in the Frugal Housewife, and cured him in about three days (Stanwood 1852-1884: 1/5/1880). It is unlikely that any of these home remedies was any more, or less, curative than was "doctor medicine". In many cases there was an overlap between the two. The home remedies withstood because, if not curative, they had proved to be palliative.

Local regular physicians explained the popularity and success of home remedies much as they do today. Dr. F. W. Hatch, telling of several cures by home remedies and talismans, said in 1873:

the fallacy lies in the assumed connection of cause and effect. The patient gets well, therefore the last prescription cures him...ascribing the recovery to the superior skill of the last comer, or the last method tried. In reality, he may have had nothing more to do with it than the eel with the cord around its neck, or the horse-chestnut which one carries in his breeches pocket (Hatch 1873: 104).

Hatch neglected to realize that what he described was also the approved empiricism of the regular profession. He did see the connection between self-limited illness and the attribution of cure that has so often been noticed by medical anthropologists studying alternative healing.

But these rational explanations did not address the desperation and anxiety of those seeking cures. Ultimately the suffering patient and his or her family will try anything, as is reflected in this medical news item of 1874: "To Stop the Ravages of Consumption in a family that had lost several of its members by the disease, in Lewiston, Maine, the body of the last one who died was disinterred and reburied with the face

downward" (PMSJ 1874 XVI(2): 97). Presumably the editors presented such items to ridicule folk beliefs, but the piteous nature of the action is what is communicated.

### Summary Chapter Thirteen

People have always relied on the reassurance of having faith in healing powers. The doctor or healer reinforces this faith by ritualizing the interaction with his or her patient. Many midwives or "old ladies" provided care in the 19th-century. They may have been gentler in their ministrations, cheaper, and more readily available. People also trusted their traditional herbs and reputations. One such "old lady" became popular in the San Francisco area in the late 1870s. She had acquired her healing powers through a mystical experience. Initially she gained a widespread reputation for her cures, but it was short-lived.

California became a center for alternative medical practice in the 19th-century. Healers such as bone-setters, worm doctors, and botanic doctors advertised in local newspapers, as did clairvoyants and astrologers. The popularity of fortune-telling was related to the economic uncertainties of the 1870s. It was hoped that personal fate would surmount social conditions. Metaphysical healing or mind cure was also a popular panacea for physical and psychological problems. The use of "blue glass" became a popular curative practice during the 1870s, capitalizing on belief in mystical powers.

Many upper and middle class residents of San Francisco consulted several Chinese practitioners such as Li-po-tai. The regular profession railed against this practice, but white patients nevertheless continued to see Chinese doctors. Most illnesses were treated at home without any

consultation. People relied on traditional home remedies. Specific preventive and therapeutic remedies were directed at devastating infectious diseases. Home medical guides were widely available, and many people made up their own, filling scrapbooks with medical recipes derived from both oral tradition and print. Self help was necessary even in a community with so many physicians because people could not afford to hire a doctor every time a family member became ill. Among the common remedies used were mustard plasters, hot and cold compresses, castor oil and cod liver oil, and herbal preparations.

There were overlaps in ingredients with the medicines used by physicians. In neither case were they much more effective than the provision of symptom alleviation. Both types of medicine were credited with curative powers when the patient recovered. But often the real explanation lay in the self-limited nature of the illness.

#### Endnotes Chapter Thirteen

<sup>1</sup>The term was used by medical contemporaries to describe all laymen (or women!) who routinely provided advice and remedies in their communities (Rosenberg 1967: 225).

<sup>2</sup>The medical profession had a "'horizontal,' undifferentiated structure" in which "almost all physicians did the same sort of things". Referrals were uncommon (Rosenberg 1967).

<sup>3</sup>The "hierarchy of resort" described by medical anthropologists in which treatment and practitioner are sought based on the cultural and etiological explanation of the disease may have been simply a matter of access here (see Romanucci-Ross 1977).

<sup>4</sup>One of the ways in which healers may be recruited according to studies of medical anthropologists is "Undergoing a profound emotional experience, involving symptoms that inspire awe and fear and signify spiritual power, and/or receiving a divine call through a dream, trance, or hallucination" (Landy 1977: 417). That this woman asked her patients no questions also suggests a divine gift.

<sup>5</sup>In addition to such practitioners, recent publications in San Francisco advertise a Psychic Reader, a School of Clairvoyant Reading and Psychic-Spiritual Healing, a couple who do Clairvoyant and Tarot Readings, a store that sells crystal balls and other "powerful specimens", a homeopathic health clinic, and an article explaining homeopathy (Life-style Nov. 1982; Whole Life Times Nov. 1982; Whole Life Times San Francisco Supplement Oct/Nov. 1982).

<sup>6</sup>Blue glass treatment was invented by General Augustus J. Pleasanton, a Philadelphia lawyer who began experiments with it in 1860, and found it to be effective against "neuralgia...failing appetite...falling hair, rheumatism...even tuberculosis and spinal meningitis" (Prieto 1938: 90). This treatment could be compared to "pyramid power" or treatment by crystals today.

<sup>7</sup>The remedies of regular medicine for this condition may not have been very much more helpful: pessaries, sponges, injections of alum in water, tonics, enemas, hip baths, exercise, and uterine wafers containing morphine. Doctors did inveigh against the usual cause of prolapsed uterus, the wearing of corsets (Haller and Haller 1974: 171-172, 176, 276).

<sup>8</sup>To save space, I have not quoted Mrs. Hill's and Mr. Batchelder's recipes exactly. However, I have not changed the spelling of any of the ingredients.

<sup>9</sup>Senna was the leaves and pods from a purgative plant found in Egypt and India. As a mixture it was called Black Draught (Roper 1974, Livingstone's Pocket Medical Dictionary).

## CHAPTER FOURTEEN: CLIMATOTHERAPY

Climate and Consumption

There were still other courses of action available to sick residents of San Francisco in the 1870s. They could take advantage of a change of scene. Ecological setting figured much more prominently in beliefs about disease etiology in the 19th-century than it does today. Both medical professionals and lay public regarded climate, season, geography, and topography as causative of disease. They believed that patterns of disease incidence varied with location and season. Since climate and location retained such a strong place in etiological beliefs, it was natural that they were interpreted as helpful in therapeutics as well. People regarded the West and California in particular as a location offering great health benefits. This reputation survives today and accounts for the origin of many alternative health approaches in this state (Baur 1959).

Many California physicians studied and wrote treatises on the finest details of local climatic and geographic conditions. The geographer Kenneth Thompson has made a study of climatology in California. He says that the medical authors of the time universally agreed as to the state's healthful and therapeutic properties. They examined a "bewildering array of only partly understood climatic phenomena", relying on poor climatic and mortality data. Thompson concludes that cures occurred probably because of misdiagnoses, psychosomatic causes, or the 'natural healing force' (Thompson 1971: 126).

Some physicians disagreed with climatology. In 1876 a letter was published locally from a Colorado doctor who argued against the claims of climatology. He complained, correctly, that not enough was known

to claim that certain localities cured phthisis. He recommended any change of climate and improved hygiene for those in early stages. But he felt that those in advanced stages of the disease should stay put (PMSJ 1876 XIX(4): 174-175).

Tuberculosis was the prime disease in climatotherapy (Baur 1959; Jones 1967). Henry Gibbons, Sr. attempted an examination of the effects of San Francisco's climate on bronchial and pulmonary problems. He argued that the sea breeze in this ocean climate was invigorating and swept away diseases, even though it bothered invalids. Similarly, the fog and winds of the city bothered ill people, but did not harm them. He saw many such invalids recover in the city; but he recommended that pulmonary consumptives spend winter and spring in southern California and only summer in San Francisco. Additionally, he recommended an outdoor life for them (Gibbons 1875). In 1878 the City Health Officer wrote of San Francisco: "Our location, our trade winds, our long dry season, and uniform low temperature, in spite of our disregard of sanitary laws, are the providential safeguards protecting us against many of the epidemics which afflict our Eastern cities" (San Francisco Municipal Reports...1877-1878: 228). In consequence of this reputation, the city became a mecca (as did southern California later) for tuberculosis sufferers. Nonetheless, some visitors disagreed. A British observer commented in 1876 on the healthiness of the San Francisco population: "For the healthy it is a good climate; but if there be a tendency to weakness it is dangerous, as all diseases take a malarial type, and once a person gets prostrated with sickness, it is difficult to get up again" (MacGregor 1876: 56). MacGregor was one of the few commentators who singled out malaria rather than tuberculosis as the sickness of this city, although he noted too that the cli-



mate was bad for consumptives.

Leading physicians were concerned through the 1870s about the excess of tuberculosis patients in San Francisco. An editorial asked in 1870 where the best place was to send consumptives. It suggested that those in different stages of the disease had different requirements. Camping out in the mountains in the summer, a horseback or sea journey suited some; but the San Francisco winds were too cold for delicate females and those in advanced stages of the disease. Likewise, the interior of the state was too hot. The writer said that the counties north of San Francisco were too much "a battle-ground between the two climates, in which wind and mist on the one hand, and a broiling sun on the other, triumph alternately". He recommended the areas to the south around Los Angeles and San Diego for the most equable climate (PMSJ Dec. 1870 No. 43: 312-317; see also Hatch 1871).

By 1873 physicians were complaining that the migration of consumptives to California was distorting health statistics. Discussing death rates in Marysville, Thomas Logan noted that,

here, as well as in Santa Barbara, the mortality by consumption, as well as the total mortality, is exaggerated by extraordinary causes--the advent of the phthisical and other sick, in search of a more favorable climate, which invalidate any legitimate deductions as to local salubrity (Logan 1873: 72-73).

Henry Gibbons, Sr. complained of the same problem in San Francisco in 1875. He recommended that those in the incipient stage of consumption travel around, treating themselves with outdoor life, or "camping out", exercising and eating wholesome food (Gibbons 1875: 235-242).

In 1878 Gibbons argued that so many patients with pulmonary consumption filled the City and County Hospital that admission had to be refused those not actually bedridden. Most came from out of state and

incurred great cost to the city. Even those who improved by their hospital stay were frustrated in permanent cure by the climate of the city, Gibbons said. He called for a State Hospital for Consumptives away from ocean winds: "An establishment of this kind would save the lives of many who now drift from all parts of the State into the inclement climate of the metropolis, and become, unjustly, a burden to that municipality". He recommended that the hospital be constructed on a pavilion plan to avoid overcrowding and take advantage of outdoor life (Gibbons 1878a).

In 1879 John S. Hittell endorsed Gibbons' call for a state hospital for consumptives. Discussing the great expense to San Francisco of these patients, he argued that many died because the climate was unfavorable to them. By now it was clear that the claimed general "salubrity" of San Francisco early in the decade did not apply to those suffering from tuberculosis as the decade ended. Hittell claimed that "Upon persons in the third stage of tubercular disease it has a highly pernicious influence". It was too chilly and foggy for those with lung diseases. He recommended a mountain near the northern town of St. Helena as an ideal place for a state consumptive hospital, since the interior and the coast were both undesirable (Hittell 1879: 498-504). This recommendation was confirmed by Dr. James Blake, who lived in these mountains. He suggested an elevation of 2000-4000 feet amid pine forests (Blake 1879: 433-434).

An interesting sideline to the concern with San Francisco's climate and its effect on disease was the movement to plant eucalyptus trees. These trees were introduced from Australia as early as 1850, and praised for their medicinal and anti-malarial qualities (Saunders 1967: 304-306). Thomas Logan and W. P. Gibbons wrote articles in 1875 describing the value of these trees, how to plant and use them. The strong medicinal

odor of the trees undoubtedly produced the belief that they could clear the air of miasms. A tincture of the leaves was also recommended as a remedy for malaria. The trees were also expected to absorb standing water and prevent its production of miasms (Logan 1875; Gibbons 1875; see also PMSJ 1874 VII(12): 570; Crawford 1876; PMSJ 1877 XX(7): 324; Hittell 1878).<sup>1</sup>

San Francisco physicians were caught in a double bind. On the one hand, they extolled the city's climate as a healthy one, freer of infectious disease than most other cities (see Chapter Five). On the other hand, the reputation of the city, and the state, brought a huge influx of tubercular patients, overwhelming city health facilities. The physicians were forced to declare the city climate dangerous for sufferers of this disease. The presence of malarial patients in the city was less dramatic because productive of lower mortality rates. But sufferers from chills and fever retreated to San Francisco from the state's interior to recover from this disease as well.

#### Country Retreats and Spas

It is not surprising that California quickly gained the reputation it retains today for healthy outdoor life. There was a prevalent 'climate' of such ideas in the late 19th-century, emphasizing outdoor exercise, healthful diet, and a general attitude, called in England "muscular Christianity". Healthy body and healthy mind were clearly equated. Members of the middle and upper classes formed walking clubs and prided themselves on covering many miles daily or weekly, much as joggers and runners do today (Haley 1978).

In 1877 Henry Gibbons, Sr. presented an article that was so

influential it was commented upon later by the French medical press (see PMSJ 1877 XX(7): 321). He discussed the therapeutic benefits of camping out, as he had in 1875. He suggested it especially for "invalids suffering from chronic disorders, particularly of the pulmonary organs". Relating various tales of people of his acquaintance who regained their health by camping out in the mountains or taking up farm labor, Gibbons endorsed California's climate for this treatment. He stressed that there was no single climate in the state, but "specimens of every climate in the world outside of the Arctic circle". He recommended the mountains of Marin County locally for camping out, or the foot-hills of Alameda County across the bay to the east, or Santa Clara County to the south, or the low mountains of the peninsula. Travelling to and from these locations, with the diversions of the trip, could be its most beneficial attribute, he said. He suggested specific equipment and activities for camping out, recommending a sojourn of a month to six weeks. He argued that camping out was cheaper than going to one of the spas. Supplying one's needs was easy, for game and fish were plentiful and butter and milk could be obtained from local farmers. Women of the party could do the cooking. Gibbons remarked on how many San Franciscans could profit from such an excursion:

Among men, dyspepsia and 'biliousness' co-operate for evil with the toil of business. Among women, nervous affections in endless forms, and debility from nursing or want of out-door exercise abound. Young children have disordered stomach or bowels, or they are continually taking cold (Gibbons 1877: 102).

Dr. James Blake commented on Gibbons' ideas in 1879 that he was "convinced by my own personal experience and by what I have seen in my patients, that arsenic, phosphorous, strychnia and all the nerve tonics combined will not half so quickly renovate a broken-down nerve apparatus

as camping out in the mountains" (Blake 1879: 437). Fully advocating the mountain climate for consumptives, Blake pointed out that there were still some problems in arranging accommodations and "good, wholesome food". Living in these mountains himself, he found he had trouble obtaining eggs, butter and milk, and had to send to San Francisco for meat. If consumptives did not get an adequate diet, and if they camped in low places where it was hotter in the daytime and cooler and damper at night, the beneficial effects of camping out would be defeated (Blake 1879).

About ten years later Dr. Clemens Richter reported the case of a tubercular woman he treated by the camping out approach. He sent her to the Santa Barbara foothills where she lived in a tent with her mother for two years. Her lungs were completely cured, and she devoted thirty more years of life, he was sorry to say, to Christian Science. Nonetheless, he attributed her cure more to the power of suggestion than to camping out (Richter 1922: 34-35).<sup>2</sup>

In the diaries and letters of contemporary San Franciscans there is much evidence of the popularity of spas or mineral springs and retreats to the countryside, as well as people migrating to California for their health. The young engineer Edward Howe found that the winds and fog of San Francisco affected his tendency to biliousness and dyspepsia, so he moved to Oakland for relief and enjoyed outings climbing Mount Tamalpais (Howe 1872-1873). B. E. Lloyd praised Oakland and other outlying regions a few years later, exclaiming, "Are you weary of city life, and require the mountain air to invigorate your frame? Scale the summit of Mount Diablo! Are you ill, and need the waters of old Ponce de Leon to reanimate you with the vigor of perpetual youth? Go and bathe in the

fountains of the old Mission San Jose!" (Lloyd 1876: 389). Howe preferred California's sea breezes to the bilious regions of New England and the midwest which affected his liver. He sought outdoors employment rather than a desk job, and at least initially enjoyed the manual labor he did in Eureka in 1871. He later found work in a hardware store too inactive for his health. Finally he took a job assaying in the Nevada mines in 1872, but by 1873 reported that to be unsatisfactory as well: "The climate does not suit me, but I suffer from cold feet, and have a continual catarrh in the nasal and bronchial organs, just as the climate of the Atlantic coast affected me" (Howe 1869-1874). Whether Howe's health and its relation to the climate were a legitimate problem or a rationalization for his "Micawber-like condition of 'waiting for something to turn up'", cannot be told. In his letters he also spoke of a friend's sister who arrived from New York to improve her health in San Francisco: "her cheeks are thin, but the bracing air and temperate climate will fatten her up, I feel quite sure" (Howe 1869-1874; 4/27/1871). He reported five months later that she had improved.

Similarly, Lucy Jones, a young lady in good society, reported among her innumerable acquaintances in 1875 a young woman visiting for her health from Boston. She brought along a six-year-old girl "who is very delicate". The plan was for friends to keep this child for a year, even giving her their name for the time, "to see if the Pacific Ocean air will strengthen her". Her mother back East was "very delicate also and may possibly spend next winter here" (Jones 1874-1875: 5/29/1875). Among her many other ill acquaintances (and it is remarkable how many there were!) was a woman who had been thrown from a horse years before and never recovered from severe back pain. She went to Lytton Springs

for her health (Jones 1874-1875: 5/29, 5/31/1875). An interesting piece of information from these letters is that Chinese household servants in San Francisco also apparently retired to hot springs for their health. Miss Jones complained in 1874 that "Yin was taken sick and went away today". Shortly thereafter he was replaced by another "chinaboy" to do the household work. Several other Chinese servants came and went before Yin's return three months later:

who should come in but 'Yin'. he had been very sick again. went to Napa. was there for his health four weeks. is quite well now. We were so glad to see him and are in hopes that he will keep well and work right on now. he looks very well. we have had so many poor chinamen lately that we know how to appreciate Yin (Jones 1874-1875: 12/2/1874).

Unfortunately, three months later Yin took sick again and was replaced by his cousin.

Mrs. Joseph Newmark's autobiography describes several retreats to San Rafael for health reasons. In the 1860s her infant daughter became ill with continuous diarrhea. The anxiety and work of caring for her made it impossible for Mrs. Newmark to work in the family store:

I was very ill and had a bad cough which did not seem to get better so San Rafael was recommended for me and the child. I was packed amid blankets into a carriage and taken over. I had a good German maid who went along for the child and my good sister and her little boy also (Newmark 1900: 8).

They all stayed with a landlady in the Marin County town. She offered to nurse Mrs. Newmark's daughter who was not receiving enough nourishment from her ill mother. Because the climate was so good in San Rafael, they remained for a few months. A few years later, after she had had two more children, Mrs. Newmark again retreated to San Rafael when all three had whooping cough:

The doctor came daily but could do nothing for the

poor children. My poor Samy was the worst; he could not swallow anything for four weeks; his throat had become so bad. So the doctor said a change of air might be the best. Said, done; I saw that we could not wait. When the doctor had gone, I had the maid wash the necessary linen, made the necessary preparations for the trip: We went to San Rafael (Newmark 1900: 9).

Two of her children improved, her daughter still coughing, but "otherwise lively and happy that she could be out of doors all day". The way in which her infant son was cured has been described in a previous chapter. When Mrs. Newmark herself was ill and awaiting an operation, she rode the Geary Street car to Golden Gate Park for a daily outing recommended by her doctor, in addition to frequently eating steaks (Newmark 1900: 12).

Mrs. Margaret Pierce described several retreats to the country in her letters. She wrote her sister-in-law in 1869 that her cousin who had previously tried Li-po-tai's treatment had now gone to a brother's in Vallejo. She said, "I believe she has given up the Chinese doctor, having no faith in him....perhaps this climate will do a great deal for her, I hope it will for I like her very much" (Pierce 1869-1888: 10/10/1869). Four months later this cousin "grew very weak and feeble" at the news of her sister's death, and retreated to Vallejo again. This move was apparently unsuccessful, for two months later she left for Los Angeles to see another brother. Mrs. Pierce commented, "I've no doubt will enjoy herself, and improve too, in the warm pleasant climate" (Pierce 1869-1888: 2/8/1870, 4/16/1870).

In 1873 Mrs. Pierce herself retreated to the country in Santa Clara. She was run down from being overactive, and suffering from her old complaints: "I lost my appetite, grew very pale & thin, and James getting frightened, sent us off to the country". Her leisure activities there cured her (Pierce 1869-1888: 7/22/1873). The next year her aunt Mary



with whom they lived, had two strokes of apoplexy and was sent to the country to recuperate (Pierce 1869-1888: 6/24/1874).

Health resorts or spas became increasingly popular in California from the 1870s into the 20th-century. Among those within reasonable distance from San Francisco were Byron Springs 68 miles away; Calistoga, Cloverdale, Napa Soda Springs, and White Sulphur Springs in Napa County approximately 50 miles north of the city; and California Geysers, Lytton Selzer Springs, Santa Rosa White Sulphur Springs, and Skagg's Hot Springs in Sonoma County approximately 100 miles north. Smaller local spas included Piedmont White Sulphur Springs in the Berkeley Hills. Each spa advertised several kinds of mineral waters for drinking, as well as special baths, douches, mud baths and exercises. These treatments were regarded as beneficial especially for dyspepsia; kidney, bowel and stomach problems; alcoholism, malaria, syphilis, rheumatism, scrofula, gout, arthritis, liver problems, glandular and skin diseases (Chittenden 1881; Anderson 1890; see also Hatch 1871; State Board of Health, Second Bien-nial Report...1873; State Board of Health, Sixth Report...1880).

Several of these spas were especially popular among well-to-do San Franciscans of the 1870s. I mentioned a woman who retreated to Lytton Springs for back pain earlier in this chapter. Its waters were advertised much later for the treatment of the diseases listed above. At its sanitarium 70 miles from San Francisco malaria was unknown, according to this ad. Treatments for many ailments featured hydrotherapy: electric, vapor, Turkish, Russian and Roman baths; "fomentations", packs, douches, oxygen treatment and "Manual and Swedish movements" (Lytton Springs Sanitarium Co. 1896).

Another popular spa was White Sulphur Springs, where friends report-

ed in 1869 that two women were "sporting amid the rustic scenes". But one of them was cured neither by this treatment, nor by Li-po-tai (Pierce 1869-1888: 8/22/1869, 10/10/1869). A young married woman went on an early excursion to this spa in 1866 with her son and her brother's family. She described the experience to her husband and daughter. They travelled by boat and "cars" to reach Napa and then to White Sulphur Springs, 20 miles away. There she bathed in 100 degree water. They travelled on to Calistoga Springs, struck by the number of "watering places" they passed. Each provided hotel rooms with meals as well as separate cottages. Calistoga Springs could accomodate 200 guests. She described the "swimming bath" dark in color because of the iron content of the water. She then related her experience in a Russian bath:

I skewed my courage up to the highest pitch, but began to perspire quite freely before I had half undressed, and upon opening the door of the little room I was so covered with the vapor I began to feel I had had enough ....The opening for the steam was about a half a yard square and there were slats across, but the water came very near to the top, and I tried my weight very cautiously...as I had no desire to try the boiling cauldron below. I began to close the door gradually but I found the steam so hot I could not stand it, when it occurred to me I had been told to put my head out of the window, (there is a little window in each room) and I found I could not only breathe easier but stand more heat. By this time great droplets of steam were falling from every part of my body, and when I found I could not stand it any longer, then I used the shower bath of tepid water. This I continued changing back and forth until I began to feel I had stayed in long enough, so putting the door down over the opening I commenced to use the towels, but it was a long time before I succeeded in drying myself, as the perspiration was most profuse. By the time I got dressed I felt weak, and was glad to lie down on a lounge in the reception room, and had it not been for dinner I think I should have gone to bed for the night (Ingalls 1865-1866: 4/8/1866, 4/17/1866).

These health spas were really resorts where people went to enjoy the novelty of 19th-century "hot tubs", pleasant climate and good meals,

as much as to recover from illness.

#### Summary Chapter Fourteen

Both physicians and people in general regarded climate and geography as instrumental in the causes and cures of disease. The climate of California was regarded as especially healthful. Invalids regularly made excursions to health spas and country retreats. Some doctors advocated "camping out" as a generally invigorating and restorative activity.

The climate of San Francisco was regarded as both helpful and dangerous to health, depending on the writer. The winds, moderate temperatures, and long dry season were lauded while the same winds, damp and fog were criticised.

Tuberculosis was the disease singled out in most discussions of climatotherapy and opinions varied as to the best locations for its treatment. It was pretty much universally recommended that consumptives leave the city itself where they were distorting health statistics. The salubrity of the city did not extend to tuberculosis victims. To improve its climate for malaria sufferers eucalyptus trees were planted throughout the city. Their aroma was regarded as healthful for clearing the air of miasms and a tincture of eucalyptus leaves was used medicinally.

On their physicians' advice or at their own instigation, many middle and upper class people went to the country or to spas such as White Sulphur Springs when they were ill. Even Chinese servants were known to go to the country when they became ill.

## Endnotes Chapter Fourteen

<sup>1</sup>Eucalyptus trees still bank the rear of San Francisco General Hospital today, protecting it from automobile exhaust fumes from the passing freeway.

<sup>2</sup>Dr. Richter introduced the damaging Weir Mitchell rest cure for hysterical women to California. He commented that the Queen of Tahiti was his patient, and she said that rest cure was traditional there. Her understanding of rest cure was obviously subject to cultural reinterpretation. What she described was young women being banished to an island to make them more desirable for marriage on their return (see also Wood 1973: 25-52).

## CONCLUDING PERSPECTIVES

Yesterday and Today: Some Connections

Nineteenth-century Americans lived with an inevitability of infectious disease, and a sense of the precariousness of life, that we find hard to imagine today. Even the "childhood diseases" many of us experienced two or three decades ago are no longer a normal part of Western life. But a century ago people of all classes lived in the presence of devastating infections. Principal causes of death between 1800 and 1875 were pulmonary tuberculosis (the single greatest cause of death over the past 200 years), infant diarrheal diseases, bacillary dysentery, typhoid fever, scarlet fever, diphtheria, and lobar pneumonia. Great epidemics of cholera, smallpox and yellow fever also swept the country (Smillie 1952: 59; Shryock 1960: 93-95; Wishnow and Steinfeld 1976: 431).

Faced with the daily menace of infectious diseases, physicians in 19th-century San Francisco struggled to control not only the diseases themselves, but also the exclusive right to interpret, define and treat them. Contemporary medical ideology revealed much about social changes occurring in an industrializing and urbanizing city. As the medical profession endeavored to circumscribe the causes and outcomes of infectious disease, its victims sought different interpretations and therapies. People commonly made use of alternative practitioners and popular and folk remedies.

There is a striking analogy between the 1870s and present-day medical practices in the San Francisco Bay Area. Today acute infectious diseases no longer have great significance. Eighty per cent of diseases today are chronic rather than acute, compared to thirty per cent fifty years ago (Public Affairs Research Group 1981, report two: 237-256). But heart disease, cancer and other chronic and stress-related ailments

again present baffling etiologies and often ineffective therapeutic responses. Because of this ambiguity, alternative medical ideologies have again acquired great popularity. Many of them have in turn simply been revived from previous forms. For example, a recent wholistic health periodical features a history of herbal medicine and numerous advertisements for its modern proponents (Whole Life Times 1983). It advertises acupuncture, nutripathy, herbal and dietary cures, massage, "synergy", homeopathy, yoga, meditation, astrology, biofeedback, Ayurvedic medicine, Chinese herbs, naturopathic medicine, and many others. As in 19th-century San Francisco, homeopaths still sell home medicine kits. Nutripathy would undoubtedly appeal to 19th-century eclectics with its combination of approaches including metabolic typing, magnetic therapy, reflexology, acupressure, flower formulas, massage, herbology, nutrient therapy and mental counseling. Magnetism is still advertised to cure arthritis, rheumatism and infections. Writers in this publication continue to use the term "allopathic" to place regular physicians in a status equivalent to alternative practitioners. Local hot springs advertise saunas, mineral baths and vegetarian meals. "Crystals" are promoted similarly to the "blue glass" phenomenon of the 1370s.

A major difference of modern appeals from those of the 19th-century is in the sort of diseases to be cured. The focus is no longer on infectious, and especially venereal diseases. Now cancer, stress diseases such as high blood pressure, chronic back problems, digestive problems, gynecological diseases and general maintenance of health and energy receive attention in these advertisements. But self-help is emphasized as it was in the 19th-century. Today mail-order cassettes replace home health care manuals (Whole Life Times April/May 1983).

This new popularity of alternative health approaches has created an environment of medical pluralism in cosmopolitan urban areas similar to that of San Francisco in the 1870s. It helps to re-establish in professional and popular minds that illness is not the exclusive property of dominant scientific medicine. Illness is culturally constructed, defined and dealt with. When the explanations of one system become unsatisfactory, others arise to replace or alter it. Even today when scientific medicine wields greater power than any other modern profession, its cultural authority can be challenged by new social definitions of disease. Recognizing this reality, the usually conservative American Medical Association has recently lifted its century-old ban on consultations and referrals between its members and alternative practitioners such as chiropractors and homeopaths.

The medical law that ended the decade of the 1870s in California has been elaborated and refined in intervening years. Recently the California Board of Medical Quality Assurance has suggested greater flexibility in the regulation of medical practice in the state. It has considered proposing to the state legislature that the province of physicians be that of "performing surgery, prescribing drugs, using ionizing radiation, diagnosing, and inserting instruments beyond body orifices". Alternative practitioners could not perform these actions; although acupuncture and chiropractic X-rays are already permitted. Alternative practitioners' other activities would thus be both limited and legitimized. They would be recognized, but would face stricter penalties for overstepping these newly defined boundaries.

Physicians thought of the 1876 law in a similar way: its purpose was to clearly define and exclude alternative practitioners from the

legitimated realm of regular practice (see Chapter Twelve). Many physicians today retain a marketplace argument in contrast to this attempt to regulate practice. They feel they have a right to remain unregulated entrepreneurs in a free society. But they do not recognize that they are no longer the free competitors of the 19th-century, but instruments of bureaucratic and corporate control. Some medical sociologists and health activists have argued that medical licensing is no longer the crucial issue in a time when the dominant profession has enormous political and economic power to shape how we think about health and illness. This is our central reality today because cultural authority, buttressed by bureaucratic power, is the prime shaping force at work in advanced industrial society (Public Affairs Research Group 1981; Starr 1982; Whole Life Times April/May 1983: 10, 29).

Medical professionals of a century ago were successful in establishing hegemony and wresting control from alternative practices primarily because their efforts coincided with the remarkable discoveries that followed upon the introduction of bacteriology. In the next century most of the killer diseases discussed in this work were eliminated from ordinary experience. Some, such as malaria, were eliminated from North America. Others, notably smallpox, were eliminated altogether. The drama of this change can be illustrated by the decrease by more than 50 per cent in America's infant mortality rate in the early 20th-century. In reality however, only those physicians who engaged in sanitation and public health work contributed to the decline in infectious diseases. Most of these diseases had already demonstrated their greatest diminution prior to the discovery of antibiotics, as the result of improved nutrition, hygiene, and general public health. The strength of scientific



medical ideology was such that credit for the amazing elimination of these diseases from ordinary life accrued to medical therapeutics nonetheless (Leavitt and Numbers 1978: 3-10).

Identification of single cause etiologies of each of these disease entities and the discovery of antibiotics and antiseptic techniques assured faith in the curative abilities of regular medicine. The popular cultural ideology of health and disease was totally redefined. Diseases became reified entities representing an objective "otherness" that seizes hold of bodies. People came to expect ailments with single identifiable causes, to be cured after the fact by the drug therapies or surgeries of scientific medicine. The equilibrium model of health and disease was almost entirely replaced by a notion of "object intrusion". Causation no longer rested in personal and social responsibility, but occurred randomly, unpredictably and uncontrollably. Scientific medicine was the only hope for cure. Although public health and hygiene against germs (the intruders) became ritualized and culturally affirmed as a way of life, little further attention was paid to preventive approaches such as improved nutrition and avoidance of environmental dangers.

Nineteenth-century social medicine had recognized multifactorial social etiologies and sources of disease in class differences. But this model was replaced by scientific explanations, based according to one physician on "a mindless application of molecular biology". Even though this movement away from a social causation ideology of disease took place, cultural explanatory constructions of disease continue to change. As people have become more disappointed with the impossibility of instant cures and sure definitions of chronic diseases that now dominate, they have begun to revive social explanatory models. Preventive health care has become increasingly emphasized as a way to avoid heart disease,

cancer, arthritis, and other chronic afflictions. It may well happen that attention to prevention will indeed eliminate these diseases as it apparently affected infectious diseases a century ago. Again, the medical profession will in fact cure only a minority of people who happen to become ill because of unavoidable environmental exposures, or because of poor personal health maintenance (see Dubos 1959; Engelhardt 1974; McKeown 1979; Public Affairs Research Group 1981, Report Two: 42). The real conquest of current ambiguities in disease may parallel that of infectious diseases; i.e., it will take place outside the medical profession.

Health statistics in 1870s San Francisco revealed many deaths from cancer and heart disease. The classes of "constitutional" and "local" diseases in contemporary disease nosology accounted for the greatest number of deaths even then. People died from cancer as well as consumption, and from heart, brain, and organ failures. But these diseases were overshadowed by the more frightening and dramatic "fevers". Alternative healers are most successful in treatment of chronic, non-life-threatening diseases, just as regular medicine has been most successful in quick antibiotic cures of acute infections. In cases of chronic disease or self-limited infections that have not received antibiotic treatment, the successful healer treats "illness" not "disease" in ethnomedical terms. The rituals involved in his or her healing activities assume great importance, for they provide a social explanation that alleviates the patient's psychological stress and metaphysical doubt. The great appeal of 19th-century homeopathy, herbal cures, patent medicines, magnetic treatment and hydrotherapy (and of their offshoots today) lay in the patient's inclusion in the social participation of healing. People

faced with stresses, environmental pressures and undefined poor health today find attractive for the same reason the approaches of "self-programming", "guided visualizations", self-hypnosis, and various forms of meditation.

#### Developing Interpretive Understanding

The contribution of medical anthropology to this history of altering social definitions of medical practices lies in explanation of the role of culture in legitimizing this change. By looking at the real experience of ordinary people, both in 1870s San Francisco and in the present time, the analyst can uncover the attitudes and expectations that give authority to one form of healing over another. Successful healers appeal to the experience of illness with all its associated culturally defined features. The whole life experience of the ill person comes into play in his or her expression of illness. Being ill has psychological, familial, occupational and financial implications, among others. In seeking treatment, the ill person desires to be healed in all of his or her suffering, including these associated changes. He or she hopes to be returned to a prior state of health and normality, to be returned to equilibrium in all aspects of life.

For example, illness is often attributed to wrongdoing or immoral behavior, implicitly or explicitly, both by individuals and the larger society. San Franciscans of the 1870s often cited excesses in various types of self-indulgence as causative of disease. A current example in San Francisco is the attribution of the herpes virus and acquired immune deficiency syndrome epidemics to sexual promiscuity. The ill person wants to have this attribution addressed in the healing process. But phys-

icians today have been deliberately trained to ignore in consultations with patients all such social explanations of disease and to focus solely on its "objective" features. Alternative therapists however, may specifically treat social and psychological causation, either directly or indirectly through the symbolism of ritual. Nineteenth-century eclectic physicians proposed an assortment of healing activities, including attention to "lifestyle" behaviors, mentally and physically soothing therapeutics, improved hygiene and diet and other approaches we would term "wholistic" today. They and homeopaths offered people a sense of control over their own fates by encouraging self-diagnosis and treatment. Patent medicines and herbal home remedies also provided people with a sense of self-determination. The sometimes exotic etiological explanations offered by alternative healers were no more inaccurate than those of regular physicians in the 19th-century. Patent medicine ads directly referred to the behavioral excesses believed to result in disease.

Alternative practitioners continue to offer this wholistic approach today, while regular medicine seeks bacterial, viral, genetic or other single causes to be eliminated by "magic bullets". Medical anthropology offers a combination of perspectives that serve to explain not only the popularity of alternative medical practice during both these time periods, but also a basis for understanding the larger social changes that occurred in the cultural construction of disease over the past century.

The ethnomedical model provides an initial perspective for the first of these tasks, the conceptual distinction between disease and illness epitomizes the great gap between popular and professional definitions of health experience. It also offers a means for characterizing

the successful healer/patient relationship of alternative therapeutics. The phenomenological experience of illness presents a very different picture from that seen in the hospital or doctor's office. In the 19th-century as in present-day San Francisco a sense of personal control over one's body and one's definition of health is very important to people. The present medical system has lost touch with this key philosophic and psychological reality because of its great success in technological intervention in acute disease episodes.

The ethnomedical approach has a highly individualized focus, odd for a social theory. Other anthropologists, sociologists and historians add the contributions of larger social forces to cultural construction of disease theory. Medical practices are ideological because they exist in a larger context of conflicting social relations. In the 19th-century industrialization in the Western world brought about profound economic changes with accompanying population movements and new social arrangements. The alteration and growth of urban environments in particular produced changed and increased disease incidence and prevalence. San Francisco is an interesting community to examine in this regard because it was the only sizeable urban setting on the developing West Coast of this period, and the destination of substantial foreign-born immigration.

The city was unusual in that it experienced in the 1870s and into the 1880s public health conditions that had already occurred in major European cities since the 1830s or before. There the sanitary reform movement was well under way and social medicine had become a dominant ideological position. As a new and isolated American city, San Francisco clung to older health values and moved only very slowly towards public health solutions. About the time such approaches were recognized, the

bacteriological revolution took place, altering the whole nature of infectious disease medicine.

San Francisco, then a city of temporary housing and primitive public works, was swept up by enormous forces of change. A sudden and exponential growth in population occurred at the same time that the nature of work changed, producing massive unemployment. The destitution and miserable living conditions of San Francisco's immigrant classes may not have been as shocking as earlier reports from cities such as New York. But they were sufficiently bad to create high rates of alcoholism, venereal disease, suicide and other indicators of social disruption and pessimism. Members of the upper classes expressed common social values of the time, allaying any sense of their own personal responsibility by beliefs in the immorality of others as the source of disease. Blatant class and ethnic prejudices were expressed in contemporary writing, especially against Chinese residents of the city. The Irish-born who suffered such calumny in other American cities were largely spared it in San Francisco even though they appeared heavily in statistics of poverty, disease, and death.

Few American physicians of this period were able to envision the role that epidemiology was eventually to play in the documentation of health and disease. The collection of vital statistics was severely limited. But San Francisco health officers compared the city's mortality rates to those of other cities in the nation and world. They assured the public in every report that San Francisco was the healthiest of cities. Etiological and social beliefs dictated certain choices in the interpretation of health statistics, as they do today. Three sources of health aberrance were singled out. Those concerned with public health wrote continually of the deplorable state of the city's sewage system,

The predominant miasmatic theory of disease reinforced beliefs in this source of "zymotic" or infectious diseases. Believers in a moral interpretation of disease etiology singled out the Chinese as the source of various disease epidemics because of their alien and impoverished way of life. Actually, statistics on their health conditions were so poor as to be totally inconclusive. Finally, some physicians were concerned that San Francisco was becoming a health mecca for tuberculosis sufferers and identified that kind of immigration as responsible for increased disease prevalence.

While each of these sources of disease existed in the city, none of them could have had the significance assigned them at the time. Examination of San Francisco health statistics demonstrates who the ill and dying really were and what diseases they suffered. About 45 per cent of deaths in the city each year were among the foreign-born, which corresponded to their percentage of the city population. Frequently as many as a third of these deaths were among the Irish. With 35-45 per cent of all deaths each year being of children under the age of ten, it is clear that many younger members of immigrant families were ill and dying. These children died of infectious diseases. The crowded and unsanitary living conditions of the poor and foreign-born were the ineluctable cause of much of San Francisco's illness and death. Ironically, medical ideology of the time flatly denied the direct communicability of these diseases until well into the 1880s. Meanwhile, manuscript sources indicate that people generally were much more likely to accept common-sense empirical evidence for disease contagion.

The "regular" medical profession stood on shaky ground in 1870s San Francisco. They quarreled among themselves and competed for clients.

Their success rate in treatment of infectious diseases was poor, despite their all-out attack on alternative practitioners to whom their patients turned. Much of the regulars' effort went into the professionalization and legitimization of their medical ideology. Almost none of these physicians engaged in research and few were interested in issues of public health. They relied on charismatic authority and identification with "science" to maintain public faith in their brand of therapeutics. In many ways their attitudes are analogous to those of physicians today.

Medical alternatives put forth the same inducements wholistic health offers today: personal control, preventive approaches, mild therapies, cheaper and less impersonal treatment, and no institutionalization. People could diagnose and treat themselves at home. The emphasis on hygiene and personal control also justified accusations against people of other classes and ethnic groups as sources of disease. Personal immorality and excessive behavior were believed to pass on to children as a constitutional diathesis or "bent" that carried its own disease susceptibility. Thus whole groups of people were responsible through immoral behavior for the incidence and prevalence of disease. People could clearly see disease brewing not only in the miasms arising from raw sewage, but also in the squalor of human living conditions. Moderation and obedience to natural law were the best preventives against disease. The affected poor had little choice in these matters however. Nor did they have the luxury of attendance by private physicians. Their use of home remedies, patent medicines and other alternatives was not a matter of free choice, but necessity.

The insecure economic and social conditions of 1870s San Francisco produced anxiety and social stress resulting in mental and physical illness. Suicide and heart disease were common. People desired to gain



control over their condition. Physicians did so by organizing themselves professionally and launching repeated attacks on their competitors, culminating at the end of the decade in a medical law defining and controlling the profession. Other San Franciscans sought control over their lives through consultation with mediums, clairvoyants, or metaphysical healers. They looked for cures they could administer to themselves in the form of patent medicines, home remedies and other palliatives. Both physicians and others blamed the special climate of San Francisco for increasing disease. They believed that retreat to the country or to the mineral springs and spas of northern California would bring relief.

Examination of the cultural context of historical disease experience makes it possible for us to become more self-conscious about our own time and place, just as does current cross-cultural research. This examination of 1870s San Francisco reveals the early struggle of precursors to today's dominant medical profession to define themselves and gain social control. Medical anthropologists have discovered again and again the conflicts between this ideology of scientific biomedicine and indigenous medical systems. Similar conflicts occur today as a century ago in our own society, as illustrated in this work. Historical research makes it possible for us to see beyond the cultural containment of our own time and place. Most social scientists concerned with health and disease have worked well within the legitimated framework of biomedicine, neither presenting alternatives nor challenging the "medicocentrism of the dominant functional theories", becoming "in fact handmaidens of biomedicine" (Eisenberg 1977: 73). But in 1870s San Francisco scientific medical interpretations were very much the products of belief and ideology. Medical paradigm changes occurred specifically around new understanding of the

etiology and treatment of infectious diseases. They also affected dramatically the historic growth of the fields of epidemiology and public health. Additionally, as foreign immigration continued into the United States through the end of the 19th-century and into the 20th, recognition of the suffering of lower classes from infectious diseases had to occur. It led to various social attitudes and responses ranging from fatalism to eugenics to class consciousness and efforts to establish public health measures.

Recent fears about mysterious infectious epidemics such as "Legionnaires' Disease", herpes, and acquired immune deficiency syndrome have joined new viral interpretations of chronic killing diseases to alter popular health perceptions. But the average person in America today still expects to be spared acute infectious diseases. He or she takes for granted the miracles of antiseptics, antibiotics, pain-killing drugs, miraculous surgery, and life-saving technology. These developments have assured the remarkable success and power of the "regular" profession. But we are still faced today with an inevitable bodily death sentence. Those who die today are much older than they were a century ago, but they also face a far more entrenched and inflexible medical establishment controlling the culture of medicine. Historical and cultural awareness makes clear the contradictions between health needs and practice. It also forces the anthropologist to recognize that the most basic questions about society revolve around those structures that have the power to inculcate beliefs and define cultural reality.

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