

Courtesy Dr. Clifton Barry III and David Dorwood, photographer, Rocky Mountain Laboratories, Hamilton, Montana.

You have two chances
One of getting the germ
And one of not
And if you get the germ
You still have two chances
One of getting the disease
And one of not
And if you get the disease
You still have two chances
One of dying
And one of not
And if you die
Well
You still have two chances

Author unknown

Poem courtesy Vernon Sundberg

Although tuberculosis patients still suffered from the microscopic rod-shaped bacteria (left) that caused the disease, the opening in 1913 of the sanitarium in Galen offered Montanans a haven and treatment. Sales of Christmas Seals (background, 1930) provided funding for anti-TB programs.

Christmas Seals courtesy Dennis Alexander, American Lung Association, Helena

“Food, Rest, & Happyness”

Limitations and Possibilities in the Early Treatment of Tuberculosis in Montana

Part II

by Connie Staudohar



Tuberculosis has infected and affected humankind for centuries. Before its bacterial origins were known, tubercular sufferers—called consumptives—were treated with compassion and often cared for at home by concerned family members. Public sentiment began to shift when Robert Koch identified the tubercle bacillus in 1882 and proved that the disease spread through direct contact with an infected person. A coupling of public concern and dread of the tubercular, discussed in Part I in the Winter 1997 issue of *Montana*, created a demand for inpatient facilities that could simultaneously care for and isolate the infected individual. In Montana, particular focus centered on the Butte miner whose cramped and unsanitary living conditions and dusty workplace created ideal breeding grounds for the spread of TB. In direct response to Butte’s soaring rates of TB, as well as other cases reported across the state, the 1911 Montana legislature unanimously passed a bill to establish a state sanitarium.

The idea for sanitariums originated in Germany where such facilities resembled health spas more than hospitals. Dr. Edward Livingston Trudeau, a tubercular American, adapted the model to suit New England and established the first American sanitarium in 1885 in Saranac Lake, New York. Trudeau’s decisions regarding location, type of treatment, and type of patient served as a model for the entire country. Numerous physicians and representatives of organizations who visited Trudeau and toured his sanitarium became convinced that a well-managed institution could offer a cure for tuberculosis.¹

Montana’s state mental institution was located at Warm Springs in the Deer Lodge valley, and in 1912 Warm Springs supervisors donated land for a sanitarium adjacent to their institution. At 4,800 feet above sea level, the atmosphere was considered beneficial for consumptives, the water supply “unsurpassed,” and the surrounding scenery “beautiful and picturesque.”² Implied, but not spoken, was the added advantage of isolation. There were no facilities for visitors and no easy means of transportation to the site. Separated from

family and community, patients thus confined posed no further threat to the public health. With these obvious advantages, Albert J. Galen, then Montana attorney general, accepted a deed for forty acres of land next to Warm Springs Hospital and thereby, deservedly or not, acquired a namesake. Construction began in summer 1912. Officially named the Montana State Tuberculosis Sanitarium, the hospital has always been known simply as Galen.³

Dr. Tuttle, then secretary of the state board of health, became Galen’s first superintendent. He began his duties by supervising construction of six cottages and a main hospital building that would become the Montana State Tuberculosis Sanitarium. The model for these buildings came from Trudeau’s sanitarium in New York. Trudeau, who admitted that he had “no idea” what buildings would best serve the tubercular, favored cottages because he found that philanthropists preferred donating a “little cottage that would be their own individual gift rather than giving money towards the erection of a larger building.” Thus, the cottage model was adopted as much for financial reasons as for treatment



From Esther G. Price, *Fighting Tuberculosis in the Rockies* (Helena, 1943), 5



National Jewish Hospital, Denver

By the early twentieth century, Montana recognized the need for modern tuberculosis treatment, especially for populations prone to spreading the disease, such as Butte miners (below, 1908–1912). The new sanitarium, named for Attorney General Albert J. Galen (below right, circa 1910) and overseen by Dr. Thomas D. Tuttle (far left), its first superintendent, was modeled after other facilities, including Denver's National Jewish Hospital (left, 1899).



MHS Photograph Archives, Helena

purposes. Trudeau's example established sanitarium care as part of a charity movement.⁴ When Montana's sanitarium first opened, the state followed Trudeau's lead by admitting county charges before privately paying patients. Whereas the state legislature allocated funds for operational costs, the counties paid the patient care expenses for those persons deemed eligible by county commissions.⁵

Dr. Tuttle admitted his first patients in January 1913. From the beginning, the staff at Galen treated tubercular men, women, and children. In its early stages, Galen was considered bleak and uninviting. It seemed the last resort for dying patients with nowhere else to turn. Despite its appearance, the facilities at Galen sought to offer the most "modern treatment" for tuberculosis. Once admitted, a patient followed a regimen based on Dr. Trudeau's "main elements of a cure," which included "an invigorating climate, open-air life, rest, regulation of daily habits and an abundant supply of nutritious fresh food."⁶

This model suited patients at other facilities, such as Trudeau's sanitarium at Saranac and Denver's National Jewish Hospital for Consumptives, because the



MHS Photograph Archives, Helena

majority of their patients were admitted in the early, or incipient, stages of their disease. Tuttle likewise sought patients who were in the early stages of TB, but it was not to be. Dr. Tuttle requested that "only hopeful cases should be sent" and asked that each patient's stay at the sanitarium "be limited to one year," but his earliest patients were seriously ill and collectively diagnosed as "far advanced." If their diagnosis seemed depressing, their accompanying prognosis was even more disturbing: "prognosis bad, terminal case"; "cure not looked for"; "doubtful"; or "advanced stage, poor." The patient's family was given the same grim information. "We are willing to admit [your wife]," Dr.

1. Sheila M. Rothman, *Living in the Shadow of Death* (New York, 1994), 205.

2. T. D. Tuttle, M.D., *Report of the Executive Board of the Montana State Tuberculosis Sanatorium, 1913–1914* (hereafter *Report of Executive Board*), folder 7, box 330, MC 35, Governors Papers, Montana Historical Society Archives, Helena (hereafter Gov. Papers).

3. Coincidentally, the name Galen also refers to the Greek doctor (130–200 A.D.) whose medical practices were used up through the Middle Ages.

4. Rothman, *Living in the Shadow*, 201–3.

5. *Report of the Executive Board*, 1–3.

6. C. E. K. Vidal, M.D., to Mrs. S. E. Morse, November 24, 1920, p. 1, folder 7, box 330, Gov. Papers; Rothman, *Living in the Shadow*, 203.

7. *Report of the Executive Board*, 2, 10; Montana State Hospital Records, 1913–1993, Galen, Montana, box 4, RS 395, Montana Historical Society Archives, Helena (hereafter Hospital Records). Patient files are confidential under state law (53-21-166 M.C.A.),



Galen's original hospital building and six cottages were constructed in 1912. By 1952 when this photograph (left) was taken, a men's ward occupied the main building, ambulatory male patients shared the cottages, and the two-story hall behind the cottages housed single nurses.

children examined had one or both parents dead. Whether from industrial accidents or disease, mining took its toll on the miners themselves and subsequently affected their vulnerable families.⁹

Tuttle wrote to one young husband, "but her condition indicates there is very little hope of the disease ever being checked." Galen's first patient was a young housewife who, upon admission, "was too weak for a thorough, complete exam." Her death less than two weeks later was an inauspicious beginning. Indeed, it was not until the 1920s that Galen became, as then residing superintendent Dr. Charles Vidal put it, a "place to cure, rather than a place for people to die."⁷

The amount of death and dying present at sanitariums set them apart from all other institutions, and the preponderance of miners from Silver Bow County set Galen apart further still. Of the 115 people admitted in the first twenty months of Galen's operation, 50 were quartz miners from Butte. During that time, 20 of the miners died and 5 were listed as unimproved.⁸

Surveys of Butte's sanitary conditions confirmed that tubercular infections came from either a miner's work place or his residence. Typically, his medical charts listed either "mines" or "lodging houses" as his primary source of exposure. Tubercular miners with families spread their disease from the mines to the kitchens, and church prayers in Butte often included a plea "to protect the women and children from disease." Children's medical charts frequently noted that a tubercular child had a parent with TB. One child reported that "he lived with his father during most of the latter's illness and helped take care of him." A health survey of Butte children in 1935 revealed that one in every five

Although a miner's physical environment might expose him to tuberculosis, his personal moral failings were blamed as well. Not only were the patients received at Galen in advanced stages of disease, Superintendent Tuttle declared, "most of them are heavy drinkers, many arriving in a state bordering on delirium tremens." Under a category titled "personal history," the men's charts invariably chronicled their drinking habits. Whether alluded to as "considerable alcohol," "rather a free drinker," or "continuously indulge[d] in intoxicants," the individual's behavior was clearly linked to the disease process.¹⁰

Once at Galen, miners diagnosed with advanced tuberculosis faced long-term separation from family and community and were given little hope for cures. Letters from family members disclose the sense of abandonment so common to sanitarium patients. After a two-year hospitalization, one niece wrote apologetically: "We have neglected you Uncle [but] we have been so busy." Other letters indicate even further estrangement and sidestep the patient altogether: "Is my brother very sick, and what is the matter with him is he very serious? please let me know the particulars." A dutiful daughter wrote: "The bonds of filial devotion oblige me to write to you and ask you to inquire into the circumstances concerning my father's condition." Inevitably, the reply was not what the family hoped. To one family, the doctor spelled out the patient's condition all too graphically. "During the winter months he is

but can be used to conduct research under rules set by the creating agency. The Department of Public Health and Human Services requires that applicants conduct scholarly research and that personally identifying information not be cited in any resulting works. Minutes of the Montana Tuberculosis Association quarterly meeting (hereafter MTA Minutes), October 20, 1920, American Lung Association of Montana Files, Helena, Montana (hereafter ALA Files).

8. *Report of the Executive Board*, 11.

9. David M. Emmons, *The Butte Irish: Class and Ethnicity in an American Mining Town, 1875-1925* (Urbana, Ill., 1989), 150; patient file, box 22, Hospital Records; Montana Director of Women's Work, Health Survey in Montana, June 3, 1935, p. 2, National Archives, Washington, D.C.

10. Patient file, box 4, Hospital Records.

practically entirely bedridden, but with the coming of spring he has shown some gain in weight and is able to be about the grounds. The outlook for recovery is hopeless, but unless he is carried off by some intercurrent infection he may live for many months and possibly years.¹¹

As if the indeterminate stay and chronic nature of their illness were not difficult enough, Galen's earliest patients had to adjust to sparse accommodations. The original legislation establishing Galen called for \$200,000 for buildings and \$100,000 for maintenance, but the amounts actually appropriated were \$20,000 and \$10,000 respectively. As a result, patient housing consisted of one main building where eight patients, the nurses, the superintendent and his family, and the kitchen help all lived together. Additionally, six small cottages—designed for two patients each—were made to serve eighteen patients. These twenty-six patients, far-advanced cases along with the new arrivals, packed the dining room for meals. Dr. Tuttle described this intimate contact as “depressing to any person, and especially so to one afflicted with tuberculosis.” Good results, he added, “could not be expected under such circumstances.”¹²

Dr. Tuttle may have had no control over the buildings or the selection of patients, but he held complete authority over the patient's daily routine, which was detailed in a rule book given to each person upon his or her arrival. Patients were to adhere to all the regulations with “strict and unquestioned obedience.” Indeed, “Down to the last detail,” the rule book asserted, patients' lives “will be regulated by strict rule.” Noncompliance would bring dismissal from the sanitarium. Knowing that months, even years, might lie ahead, patients entering the “san” traded their independence for what one historian termed a “career at being a patient.”¹³

Galen offered the invigorating climate Trudeau and Tuttle endorsed, and the staff provided a strictly enforced daily routine. All cottage patients were required to live strictly out-of-doors. Rules stated that patients should be

in closed rooms only when dressing. They sleep in open porches that are provided with canvas screens, which, however are closed only during storms. Cold weather does not deter them from sleeping in the open, sufficient covering and properly made beds

provide sufficient protection from the cold. During stormy weather the patients are permitted to come into the reception room, which is by far too small.

A partial list of property on hand suggests how the staff supplied the patients for “sufficient protection from the cold.” There were listed “21½ dozen blankets, 26¼ dozen sheets, 110 undershirts, 96 drawers, 4 Mittens, 8 Artics [arctics] and 56 Boudoir Slippers.” Considering Galen's twenty-six bed capacity, these were ample supplies.¹⁴

Provision of an appropriate atmosphere extended to a patient's activities as well. An “atmosphere” of quiet that promoted rest was essential to treatment, and patients were required to retire at nine o'clock at night. They also were to lie down from one to three in the afternoon. These were periods of absolute quiet. No talking, reading, or noise of any kind was permitted. Patients with even slight temperatures were assigned to total bed rest. The measurement of one's temperature, therefore, took on ritual proportions. One patient recalled that the “only way we could tell whether we were getting well or dying was by the privileges we were granted.”¹⁵ A normal temperature allowed a patient to take limited exercise, a welcome respite from monotony.

In addition to fresh air and rest, nutritious food was considered a cornerstone of treatment and a means for measuring progress. Dr. Tuttle listed in detail the menus provided for the patients. With healthy meals patients were to “drink a glass of milk at seven o'clock in the morning, another at ten in the morning, another at three in the afternoon and an eggnog at nine in the evening.” This was no ordinary milk, for the milk supplied was “strictly four percent butter fat and the cream twenty-eight percent.”¹⁶

The temperature-taking ritual was matched in importance only by “weighing-in” day. One's weight became a measure both of physical and psychological well-being. Jessamyn West, who wrote a memoir about her sanitarium stay in California, admitted to adding a bottle of hand lotion to her bathrobe pocket on weighing day. To maintain this “weight gain,” she added extra jars and bottles to her pockets until she described herself as “clanking onto the scales as burdened as a pack mule.” “I had become my own medicine man,” she wrote. “Deprived of a tube of toothpaste or lightened by a missing bar of soap, I might have developed galloping consumption because of the weight loss.”¹⁷ The tubercular's fear of weight loss was not imaginary. The term consumption literally meant being consumed and

11. *Ibid.*; letter to Governor Frank H. Cooney, August 31, 1933, folder 6, box 73, Gov. Papers; patient file, box 11, Hospital Records.

12. Esther G. Price, *Fighting Tuberculosis in the Rockies* (Helena, Mont., 1943), 13; *Report of the Executive Board*, 5.

13. Montana State Tuberculosis Sanitarium (hereafter Sanitarium), *Rules Governing Patients* (Galen, Mont., 1919).

14. *Report of the Executive Board*, 7, 14.



Powell County Museum, Deer Lodge

Galen's Pavilion (above), built in 1917 by Montana State Prison labor, accommodated the turn-of-the-century open-air treatment that emphasized patient exposure to pure, cold air for up to twenty-four hours a day. Doctors Alexander McDonald (far left, 1913) and Charles Vidal (left, 1915) served as Galen's second and third superintendents.

(both Doctors) MHS Photograph Archives, Helena

wasting away, and an obvious sign was a gradual, steady loss of weight.

Galen's medical staff expanded upon Trudeau's "main elements of a cure" by including "happyness," along with food and rest, as one of the "three most important things" in tuberculosis treatment. Doctors generally believed that tubercular sufferers were "a constant prey to morbid discontent." As one doctor wrote, "it didn't matter so much about what the patient has in his lungs—it's what he has in his head." Dr. Charles Vidal—who became the third medical superintendent of Galen in 1919 after Dr. Tuttle's successor, Dr. Alexander MacDonald, died—thought it was only a "lack of equipment" that prevented him from supplying "happyness" to his patients. Dr. Vidal lobbied for an amusement hall, a "place large enough where movies could be shown and entertainments staged." Although a "movie picture machine" was eventually purchased and entertainment staged for the patients, they served only as temporary distractions in an otherwise stark environment.¹⁸

If the facilities at Galen were considered limited overall, provisions for the care of tubercular women and children were especially lacking. Although the largest number of patients were Butte miners in advanced stages of tuberculosis, women comprised roughly 20 percent of the total patient population during Galen's first ten years. An offer to the governor in 1916 to build a unit at the TB hospital from "we club women of Montana" could hardly have come at a better time. While club women worked on fund-raising for the construction of a women's building, the Pavilion Build-

ing, built in 1917, was used to house additional women patients who "of necessity require[d] more privacy and greater bedside care." The original cottages were enlarged and a new men's hospital was completed in 1920, yet there remained a waiting list for admission. Women and children, in particular, needed a place of their own.¹⁹

State women's clubs were actively involved in tuberculosis work throughout the early years of Galen's development and paralleled national women's club work that specifically promoted education for the protection of children and the prevention of disease. Members of the Montana Federation of Women's Clubs were in key leadership positions in two significant antituberculosis organizations founded in 1916: the Montana Tuberculosis Association (MTA) and the Butte Anti-Tuberculosis Society. MTA fund-raising also helped provide direct services to children such as sending those at risk to Sunshine Camps in hopes of building their resistance to TB, hiring a nurse for the Indian reservations, and supplying a teacher for those children already at Galen. With cooperation and guidance from the national organization, the MTA yearly sponsored the popular and successful Christmas Seal sale campaign. Since its introduction in 1907, the affordable and familiar Christmas Seal had become a national symbol of a public crusade against the disease. The "Seal Sale" was the MTA's prime source of funds. By contrast, the Butte Anti-Tuberculosis Society's work centered initially on tubercular miners.²⁰

Dr. Caroline McGill, a Butte physician, worked with Helena's Dr. Atwater to spearhead the efforts of these antituberculosis organizations. Dr. McGill focused on

15. Ibid., 9; Betty McDonald, *The Plague and I* (Philadelphia, 1948), 142.

16. *Report of the Executive Board*, 9.

17. Jessamyn West, *The Woman Said Yes* (San Diego, 1976), 38.

18. Rothman, *Living in the Shadow*, 232-33; Vidal to Morse, November 24, 1920.

19. C. E. K. Vidal, M.D., *Report of the Condition of the Montana State Tuberculosis Sanitarium, January 1, 1927*, folder 8, box 330, Gov. Papers; Vidal to Governor Cooney, folder 6, box 79, *ibid.*

20. MTA Minutes, July 11, 1921, ALA Files; *Montana Woman*, December 1925, p. 9, September 1928, p. 16.

the local level in Butte, while Dr. Atwater, who had lobbied steadily and determinedly for the antituberculosis campaign since Galen's founding, worked on the state level with the MTA. Dr. McGill, the state's first pathologist, had an established medical practice in Butte that brought her in direct contact with the health care needs of miners and their families. She also worked with Jim McNally in his early efforts to combat tuberculosis in Montana and to organize the Butte Anti-Tuberculosis Society. The prominence of doctors Atwater and McGill drew attention to the antituberculosis cause. They generated support from professional groups, and their medical practices lent aid from lay individuals.

The increasing number of patients at Galen was one measure of how successful Progressive reformers were at public education. Local women's clubs had used sales of Christmas Seals as a means to educate the public about tuberculosis and to finance club projects since 1915. When federation club president Elinor Walsh suggested that funds from the sale of Christmas Seals be used to construct a building for women patients at Galen, the idea was approved unanimously. When Mrs. Walsh died before the fund-raising was completed, Dr. Atwater proposed that the women's building be considered a memorial to Mrs. Walsh. It was dedicated as the Elinor Walsh Memorial Cottage in 1920, with Dr. Atwater ceremoniously laying the cornerstone. The building opened in 1921. Funds for the cottage came from Christmas Seal proceeds, to which Senator Walsh personally contributed \$5,000 and the Federation of Women's Clubs donated \$2,500.²¹

With opening of the Elinor Walsh Cottage, Galen could accommodate roughly ninety patients, ten of whom were women. The cottage filled immediately, and within a month Superintendent Vidal reported that thirty-eight people, including five women, were on a

waiting list. Demands for admission poured in, and Dr. Vidal blamed the congestion on the "profession's persisting in sending us hopelessly advanced cases. I cannot manufacture accommodations out of thin air."²²

However frustrating the situation for Galen staff, those on the waiting list experienced even greater hardships. They lived in limbo. The housewife beseeching Governor Dixon in 1921 to "kindly tell me what [I] can do" was among those who had heard from "doctors, nurses and [the] State Board of Health 'Out with you. Go to Galen.'" Galen staff had replied: "We are crowded and have no more room. You must wait." While they waited—weeks or months—their houses could be marked with warning or quarantine placards that either warned or forbade others from entering. Pets were excluded from sick persons' rooms or were removed entirely from the premises. Library books could not be checked out. If a book had been loaned to a tubercular inadvertently, it could not be recirculated until a thorough cleaning ensued, exposing its pages to sunlight and air for at least four weeks.²³ Concern for the patients in waiting prompted family and friends to intercede, and the fear of catching TB lent an urgency to pleas and underscored the anxiety families caring for a tubercular experienced.

When the long-awaited opening finally occurred, the tubercular person hurried to Galen, signed his or her agreement to all rules and regulations, and was ushered to accommodations appreciably improved in the decade since the sanitarium's inception. For the tubercular sufferer who wrote to Governor Dixon, a two-month wait ended with her admission to the Walsh Cottage, considered the "last word in comfort and efficiency." There she received the treatment she had long sought and the medical care she needed. On the day of her arrival, an exam by Dr. Vidal revealed far-advanced pulmonary tuberculosis. In a let-



Museum of the Rockies, Bozeman

Early Butte physician and antituberculosis activist, Dr. Caroline McGill (above, 1925), knew through her medical practice of the serious health risks miners and their families often faced.

21. Montana Tuberculosis Association, *Volunteer*, February 1956, p. 1, ALA Files; "Program of Dedication of Eleanor Walsh Memorial," September 29, 1920, ALA Files; Price, *Fighting Tuberculosis*, 41.

22. Vidal to Governor Dixon, January 18, 1921, Vidal to patient's friend, January 15, 1921, folder 6, box 34, Gov. Papers.

23. Letter to Governor Dixon, January 8, 1921, folder 5, box 34, Gov. Papers; Montana State Board of Health, "Communicable and Other Reportable Diseases" (Helena, Mont., 1965), 10-11.

24. Vidal to woman, July 19, 1921, box 13, Vidal to father, April 25, March 28, 1921, box 12, Hospital Records.

25. Father to Vidal, April 22, 1921, box 12, *ibid*; Rothman, *Living in the Shadow*, 245.

26. Patient to Vidal, July 19, 1930, box 34, Hospital Records.

27. Daughter to Vidal, April 1, 1932, box 34, Vidal to daughter, January 31, 1931, box 34, *ibid*.

28. Vidal to county auditor, November 29, 1921, box 13, *ibid*.

ter to her father, Dr. Vidal wrote that “he did not feel justified in raising any hopes for a permanent recovery.” Her afternoon fevers returned, and she was unable to keep down her meals. She required continuous nursing care, more than the homelike atmosphere the cottage provided. Her last move was to a female ward for advanced tubercular cases. There she was “practically, entirely confined to bed.” Receiving the treatment she needed too late to be of help, she died less than six months later at the age of twenty-eight.²⁴

Tuberculars sought sanitarium treatment for medical care and to escape the stigma attached to their illness. Once admitted, however, they often felt profoundly isolated. To discourage attempts to leave, administrators forbade them outside contact for the first few weeks. Relatives and friends often sent caring letters, but to the doctors they typically wrote: “above all persuade her to stay.” Such worries were legitimate; national statistics showed that 10 percent to 30 percent of sanitarium patients left within a month of arrival.²⁵

Patients who left against medical advice commonly faced anger and disappointment from their families and from health authorities. If they tried to return to the sanitarium, they went to the end of the waiting list. One patient left Galen “without the knowledge and consent of the medical staff” after just one week. In three months she requested readmission. To Dr. Vidal she wrote:

I have decided to try the Sanitarium again am sorry I did not stay but you know not being used to so much noise I just couldnt stand it or thought I couldnt so just caul . . . I can go anytime.²⁶

With a great sense of urgency, her daughter wrote to Dr. Vidal: “But wont you please just consider her one time more *just* for my familys sake because you dont understand Dr how terrible its been for me since Mother came home.” What made the situation “terrible” was the fear that her tuberculosis would spread to other family members. “If it was just myself, I could make out all right,” the patient’s daughter said, but added:

The way I am thinking if you don’t consider Mother there is such a thing as the whole family coming down with it the Health nurse said it was a terrible thing to have Mother with children she [said that] 9 out of every 10 cases that developed were contracted from old cases of T. B.

Despite such pleas, Dr. Vidal informed the family that Galen was full and had “fifty seven on the waiting list.” Although there was much correspondence back and forth, he never addressed the family’s concern of contagion. Six months later, this fifty-year-old patient was finally readmitted and stayed for 290 days. Upon discharge, her tuberculosis was said to have been “arrested” but not cured.²⁷

Tubercular children waited for admission to Galen along with the others. They had been hospitalized at Galen since its founding despite the lack of special accommodations for their care. Children aged two to sixteen shared wards with adults, and the intermingling created problems for staff and patients alike. Dr. Vidal reported that “it is all very well when the [children] are in bed but when they are up and allowed a certain amount of liberty there are likely to be complications.”²⁸

The problems were discipline and decorum. Children were expected to follow the same routine as adults, and administrators took complete control of their behavior. Patient siblings were separated as were patient parents and children. The experience of a sister and brother, twelve and ten years old, conveys a sense of hospital atmosphere. When their mother and older sister died of tuberculosis after extended illnesses, a Red Cross Home Service worker sent the children by train to Galen in 1923. The girl was admitted to the Walsh Cottage and her younger brother to the Hospital Building. They were given cod liver oil and placed on bed rest. After six weeks of this treatment, Dr. Vidal said “the boy went on a rampage—again—and injured one of the patients by throwing rocks.” To this obvious infraction, Dr. Vidal added a long-standing concern regarding girls. “For impressionable girls of her age who are physically well Galen . . . does not afford an ideal environment.”²⁹ Vidal worried about the intermingling of sexes—a strict taboo

State Historic Preservation Office, MHS, Helena



The Montana Federation of Women’s Clubs sold Christmas Seals to finance a host of public anti-TB programs and, in 1920, to build a women’s building at Galen. They dedicated the cottage (left, 1980) to their former state president and antituberculosis campaigner, Elinor Walsh.

at Galen and sanitariums in general. Given the moral climate of the times and children's special needs, separate facilities for children seemed the only answer.

Children, a special focus for the antituberculosis crusade, still needed special protection because, as one doctor said, the general public persisted in "spitting" and "sneezing" and spreading disease germs. Since the turn of the century, evidence showed that most tuberculosis developed in childhood. While some states opened "Preventorium" designed to keep at-risk children healthy, Montana communities sponsored "Sunshine Camps" for undernourished children. These camps served to bolster children's health through diet, rest, and sunshine. At one camp, "automobiles cut out of magazines were ranged on the outside of the cook cart and sped forward four inches every time its owner gained a quarter of a pound."³⁰

In addition to strengthening children's defenses against disease, sunshine camps fostered widespread interest in children's health. Having made preventive work among children one of its primary aims, the Montana Tuberculosis Association directed funds from its yearly Christmas Seal sale to assist sunshine camps and milk clinics for children and to conduct statewide surveys and studies. One survey revealed that an estimated five hundred Montana children had tuberculosis in 1921. Receiving the results, Dr. Vidal passed them on to the governor with the following admonition: "Not a week passes but Galen receives requests that some suffering child be sent to us for care. Are they to be refused their chance for escape from chronic invalidism or death?"³¹

In response, the Montana legislature appropriated \$16,000 for a thirty-bed children's building at Galen in 1923. Whereas the Elinor Walsh Cottage afforded a semblance of home to women patients, the new building was to provide treatment suitable to children's special needs, and, equally important, to separate them from Galen's adult population.³² The "Sunshine Pavilion" housed children in separate wards—one for boys and one for girls. A sun deck extended along one side of the building, and all rooms opened onto it by means of wide french doors.

A Swiss physician, Auguste Rollier, had popularized sunshine treatment for the types of tuberculosis most commonly found among children—TB of the skin, bones, and joints. Termed "heliotherapy," this treatment consisted of exposure to direct sunlight in gradually increasing doses. Dr. Vidal described "wheeling

little patients out to the sunporch" to receive their daily doses of sun. "Day by day," explained Vidal, "another section of the [child's] body was exposed and the time of exposure lengthened by five minute intervals until the patient, clothed only in bathing trunks, had exposed the whole body for one hour." When their young body had "bronzed" under the sun's rays, Vidal said "there was usually a complete arrest of the tubercular processes." Treatment took from six months to a year.³³ When Dr. Atwater visited the children's building in 1928, she found the children no longer confined to "their straight white beds" but instead "in a broad sun parlor looking brown and healthy."³⁴ Because their disease was often in early stages, children responded well to treatment, which gratified caregivers and justified the state's efforts and expenditures.



Women's clubs, primarily through the MTA, were actively involved in the health and well-being of Montana children. The organization's newsletter, *The Montana Woman*, carried stories on Sunshine Camps, Galen's Sunshine Pavilion, and a reminder that the "first effort for the establishment of a tuberculosis sanitarium in Montana originated with the Women's Clubs of the state." The newsletter asked for all types of contributions: "Ice-skates, skis and toboggans. Something that your children have outgrown or are tired of or can do without." The MTA also asked women to become "[their] brother's keeper—and also his children's."³⁵

Advocacy for children reflected the same blend of concern and fear that pervaded the antituberculosis campaign generally. Leaders told their women's club members to identify undernourished or sickly children in their communities and then speak to their parents and doctors about sanitarium care. Intended to provide children with early treatment in hopes of a cure, this indirect reporting also served to remove potentially infectious children from the community. "Your own children may be infected at school, or in a crowd, if some one of these cases is neglected," warned Dr. Atwater.³⁶ Such concern, motivated largely by fear, kept a steady flow of patients—young and old—to sanitariums throughout the first half of the twentieth century.

Patients entered Galen without knowing how long they would stay. One patient wrote that "being sent to

29. Vidal to doctor, August 4, 1924, box 21, Vidal to Red Cross worker, April 10, June 11, 1923, box 18, Vidal to county auditor, November 29, 1921, box 13, all in *ibid.*

30. *Montana Woman*, December 1925, p. 8.

31. Vidal to Governor Dixon, March 5, 1921, folder 6, box 34, Gov. Papers.

32. Dr. Charles Vidal, *Report of the Montana State Tuberculosis Sanitarium*, Galen, Montana, December 1, 1924, p. 2, folder 8, box 330, Gov. Papers.

33. *Montana Woman*, January 1925, p. 1.

34. *Ibid.*, December 1928, p. 7.

35. *Ibid.*, December 1925, p. 9, December 1928, p. 7.



Courtesy Diane Sands



American Lung Association, Helena

an institution is no game of Parcheesi and not knowing when, or if you'll get out doesn't make it any easier. At least the criminal knows what his sentence is."³⁷ Patients responded with a sanitarium subculture that included black humor and a language all their own. Most narratives of sanitarium life refer to some form of this subculture. Patient newsletters represented one outlet. The *Gay Lung* reported patients' news and writing from Galen; in New Mexico *The Killgloom Gazette* served the same purpose. Sanitarium slang also represented a form of coping. "Spitting rubies" or "streaking" meant blood was present in your sputum. Patients referred to themselves as "lungers," and those with silicosis as the "black lungers." "Temp sticks" were the thermometers and lidded sputum cups were referred to as patients' music boxes, which when opened played *Nearer My God to Thee*. "All of the san lingo was at first repugnant to me," wrote Jessamyn West. "But to refuse to learn or use it was like refusing to learn or speak anything but English while living in a foreign land."³⁸ Newsletters and slang created a bond among the patients as they adapted to sanitarium life and softened the pervasive feelings of isolation and discouragement.

The consolation of friendship worked similarly. As a Galen patient in the 1940s remembered:

I had spots on my lungs, had lost lots of weight is why I was sent there. I was in a private room. No one entered except the staff and they all gowned and masked. [I was] only allowed out of bed for the first 3 weeks for bathroom needs. After no positive tests my door was left open, [and] in a few days

Though living at the sanitarium reduced the stigma associated with tuberculosis, patients like those shown here still had to cope with loneliness, isolation, and the uncertain lengths of stay. To ease the distress, Galen patients shared friendship, patient newsletters, black humor, and slang references to their symptoms.

I was moved into a room with another patient. We were very compatible. My name is Frances Jean hers Frances Jane. Both husbands sheep ranchers. I had 2 little daughters she had 1 son. Both unbearably homesick! At first every one was so on guard to be around you. We sat in the yard and the Dr.'s child told us she couldn't come near or talk to us because we were patients. My grandmother sent

a box of chocolates every week. It was during the War so they were a treat, but the nurses would never take any. Finally, one of them told me they would love to have some, but only if they were sealed in cellophane and had never been opened.³⁹

Frances left Galen after two months and never had a recurrence of her symptoms. Other patients were in the sanitarium for years.

The average length of stay at Galen steadily increased. Some patients became so institutionalized they did not want to go home. A nurse at Galen recalled patients who held their thermometers up to bed lights so they would appear to have a temperature. Others, she said, swapped sputum specimens with patients known to be positive. Some patients dreaded discharge because once out on their own they struggled to maintain their health and resume their former lives. Dr. Vidal reported that two "graduates" of Galen had been readmitted because the work they had done was "too strenuous" and they had a relapse. Similarly, two young girls who had returned home and resumed school were told to return to Galen after the school year for an exam "and possibly to spend the summer months here." Reports from Galen in the 1930s listed twelve "ex-patients" as employees, including the new superintendent of Galen, Dr. Frank I. Terrill, who as a self-diagnosed

36. Ibid., December 1928, p. 7.

37. McDonald, *Plague and I*, 47.

38. Rothman, *Living in the Shadow*, 241; West, *The Woman Said Yes*, 34.

39. Frances Petrie to author, July 25, 1995.

40. Lucille Paddock Balfour to author, December 15, 1995; MTA Minutes, October 20, 1920, ALA Files; Vidal to parent, September 1, 1926, box 28, Hospital Records; Sanitarium, *Biennial Report*, July 1930-1932, p. 6, folder 8, box 330, Gov. Papers.

41. Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia, 1992), 264; Sanitarium, *Fifty Years of Progress, 1913-1963* (Galen, Mont., 1963).



Hoping to make TB a thing of the past, mobile screening units visited Montana communities taking chest x-rays. The unit in the photograph (left) checked the lungs of citizens who gathered next to the capitol in Helena on February 2, 1953.

TB victim, had been a patient at Galen for ten months in the 1920s.⁴⁰

Despite the costs to personal freedom, many people agreed that sanitariums “met the hopes and needs of the sick and assuaged the fears of the healthy.” With longer hospital stays, the proportion of people institutionalized for TB continued to grow. Admissions to Galen climbed throughout the 1930s and 1940s. A new receiving hospital, built in 1937, increased Galen’s patient capacity 40 percent and filled to capacity almost immediately. Galen authorities felt they were both “resolving [their] responsibility” for the problem of tuberculosis in the state and “relieving the problem of [tubercular] people coming in contact with the general public.”⁴¹

As the rate of sanitarium admissions rose, the death rate fell. The work of sanitariums and health departments was part of a combination of factors contributing to the decline of tuberculosis. TB infection rates had begun to drop as early as the 1880s and continued to decline before sanitariums experienced a larger volume of admissions with longer stays. Socioeconomic conditions improved for many, and by the 1920s “the middle and upper classes . . . enjoyed an unprecedented freedom” from the infectious diseases that plagued their parents and grandparents. Technological advances, such as ventilation and sewer systems, improved overall living and working conditions, and by World War II, the death rate was less than a quarter of what it had been in the early 1900s.⁴²

Declining TB rates encouraged health authorities and reassured the public, but the disease did not disappear. Galen had more than twelve hundred admissions between 1943 and 1947. Not until the 1940s were chemical cures for TB developed. These discoveries—streptomycin in 1943, para-amino salicylic acid (PAS)

in 1944, and isoniazid (INH) in 1952—caused the downturn of clinical tuberculosis in the United States and other developed countries. With these developments, patients who had lingered in sanitariums for years were cured with a regimen of the combined drugs. Galen’s case load dropped so significantly that vacated facilities were filled with mentally retarded residents from the State Training School in Boulder. Public health officials initiated widespread screenings of school children, factory workers, community members, and soldiers. Those testing positive were given the new drug treatment. Within ten years of streptomycin’s discovery, national death rates from TB declined to ten per one hundred thousand.⁴³

Whereas Progressive Era reformers believed that education and inpatient treatment would prevent the spread of tuberculosis, doctors and health officials in the 1940s and 1950s were confident that screening and medication would eradicate TB altogether. “Tuberculosis in Montana can be a thing of the past within the next 25 or 30 years,” Dr. Terrill claimed in 1945. A similar statement in 1958 said that tuberculosis “is expected to cease to be a public health problem, and before the end of this century it may become so rare in the US as to constitute a medical curiosity.”⁴⁴

After decades of declining rates, however, TB cases began to climb steadily in 1985. By the 1990s, TB was back in the news. The same conditions that fueled its spread in the nineteenth century—crowding, malnutrition, poverty, and vulnerable immigrant populations—have contributed to a resurgence. In addition, the increase in Human Immunodeficiency Virus (HIV) infections and Acquired Immunodeficiency Syndrome (AIDS) cases created a population of people particularly susceptible to tuberculosis because of their diminished immune response. Two research scientists, John

42. Bates, *Bargaining for Life*, 323-25; Diane Garey and Lawrence R. Hott, *The People’s Plague: Tuberculosis in America*, two-part documentary film, 114 minutes, distributed by Florentine Films, 1995.

43. Sanitarium, *Fifty Years*; Rothman, *Living in the Shadow*, 247-49.

44. Bozeman *Chronicle*, June 22, 1945; Rothman, *Living in the Shadow*, 249.

45. John K. Spitznagel and William R. Jacobs, “Mycobacteria: Tuberculosis and Leprosy,” in *Mechanisms of Microbial Disease*, ed. Moselio Schaechter, Gerald Medoff, and Barry I. Eisenstein (Baltimore, 1993), 327.

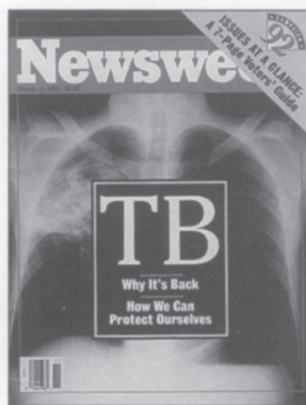
46. Geoffrey Cowley, E. A. Leonard, and Mary Hager, “Tuberculosis: An Old Killer Returns,” *Newsweek*, March 16, 1992, p. 56.

47. Spitznagel and Jacobs, “Mycobacteria,” 328-30; Garey and Hott, *People’s Plague*.

K. Spitznagel and William R. Jacobs, reported that “the incidence of tuberculosis among AIDS patients is 500 times that of the general population.” Spitznagel and Jacobs noted that not only is a person infected with HIV more susceptible to TB, the man or woman who had previous exposure was more likely to develop an active case. To these researchers, the increase in AIDS cases was responsible for the reversal of the long downward trend in TB.⁴⁵ “Still, there is no question the TB explosion could be stopped,” *Newsweek* reporters wrote in March 1992. “Tuberculosis is not an incurable illness, just an illness we’re failing to cure.”⁴⁶

Modern antitubercular drugs, coupled with such lessons from the past as effective sanitation, screening, diagnosis, and treatment, could help control the current resurgence. Compliance from patients and consistency from providers are necessary to effective control. Noncompliant patients face “recalcitrant patient” laws that provide authority to commit patients with active cases of TB to approved facilities. As a further means of TB control, some have suggested that sanitariums reopen to isolate patients with drug-resistant strains of TB. At the end of the nineteenth century, Dr. Herman Biggs, medical officer of the New York City Department of Health, declared that “the welfare of the healthy majority was more important than the rights of sick individuals.”⁴⁷ Echoes of that sentiment have reverberated throughout the twentieth century.

Consumption came out of the closet at the end of the nineteenth century and became known by a new name: tuberculosis. The disease has come back at the close of the twentieth century. The Jim McNallys, Dr. Mary Atwaters, and Elinor Walshes cared deeply about tuberculosis sufferers and provided for those in need. That their efforts constrained tuberculars along with helping them is part of the historical record. The story of Galen and the early public health movement has a similar legacy and contributes similarly to understanding contemporary events. Fear of contagion motivated



After decades of decline, tuberculosis rates have begun to climb, as *Newsweek* reported in March 1992. Young Christmas Seal publicists like those at right (1962) may be called upon again to fight a debilitating disease once believed conquered.

people to form organizations and institutions to isolate and contain the tubercular. Although fear of catching TB may have been the base motive, compassion framed the antituberculosis movement and ultimately resulted in providing treatment for chronically ill tubercular people. Understanding how that fear moved people to action is crucial to understanding tuberculosis treatment in the twentieth century.

The history of tuberculosis in Montana is finally the story of the thousands of people who had TB and lived with it. Their struggle reminds us how earlier generations dealt with chronic, incurable diseases. It reminds us, too, that other diseases such as HIV or AIDS can stigmatize their sufferers with shame and isolation. The story of the tubercular sufferer who wrote to the governor of her humiliation in 1921, before entering the sanitarium, illustrates how TB was experienced emotionally as well as physically. A generation earlier, she would have been treated with pity, not censure, and would have been allowed to be among others rather than isolated. Public sentiment and social rules profoundly influence the treatment of the chronically ill, then and now. *M*

CONNIE STAUDOCHAR is a Bozeman, Montana, independent scholar who holds a bachelor's degree in nursing from the University of Washington and a master's degree in history from Montana State University, Bozeman. She has written a self-guided tour booklet on Bozeman women's history and has received a fellowship from the Montana Committee for the Humanities to write a juvenile biography of Dr. Caroline McGill. This article is based on research she did at the Montana Historical Society as a Bradley fellow in 1995.



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