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IN THE CENTER OF THE PLAGUE: TUBERCULOSIS AND THE EXPERIENCE OF SPACE, TIME AND TELEOLOGY, 1910–1940

By

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ABSTRACT

IN THE CENTER OF THE PLAGUE:
TUBERCULOSIS AND THE EXPERIENCE OF
SPACE, TIME AND TELEOLOGY, 1910–1940

By

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In this project, I examine what it was like to be a tuberculosis patient in the American sanatoria of the early twentieth–century. Several historians of the sanatorium experience have argued that these institutions should be considered incarcerative, similar to prisons and lunatic asylums of the day, insofar as they greatly restricted individual freedom. I take this work a step further by focusing on a sanatorium treatment that enforced a particularly extreme form of confinement and restriction: prolonged and complete bed rest. I show that, despite the medical community's best intentions, this treatment was "psychically invasive." That is, bed rest contributed to bringing about a fundamental change in how patients related to the world around them, eventually resulting in a radical alteration of their perception of space and time, as well as their conception of life goals.

For my mother and the memory of my father

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It gives me great satisfaction to be able to thank those individuals and institutions whose assistance contributed to the completion of this project. First, I would like to express my gratitude to chair of my thesis committee, Peter Vinten–Johansen. No one could ask for a more responsive advisor or dedicated teacher. I would also like to thank the other members of my committee, Steve Rachman, who was largely responsible for inspiring me to undertake this project, and Tom Tomlinson, who encouraged my scholarly pursuits in the Interdisciplinary Programs in Health and Humanities from the beginning of my graduate education. In addition to the comments and suggestions of my committee members, the project also benefited from the helpful insights of Maureen Flanagan. On a more personal note, I wish to recognize my mother, to whom this thesis is dedicated, for her steadfast love and support of my professional endeavors. And finally, I want to thank my husband, Damon Linker. I am grateful for his ideas and suggestions as well as his abiding support and commitment, all of which made the completion of this project possible.

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INTRODUCTION

It was October 1938, the third week of her sanatorium stay, and Betty MacDonald had been confined to bed for a total of twenty–one days. Looking for something to divert her attention from the "cold, green walls" around her, she reached toward her nightstand for a copy of the sanatorium rule–book, a pamphlet that every patient received upon admission, and skimmed through some of the introductory lessons about tuberculosis. Lesson number five ended with the following rule: "The cure of tuberculosis is not medicine but a new regime of living."[1]

This quotation captures the essential character of the tuberculosis experience in the sanatoria across the United States between 1910 and 1940. In the early twentieth–century, patients with tuberculosis were rarely treated with pharmaceuticals. Instead, they were often advised to take up residence at a sanatorium, to leave the activities and demands of their daily lives behind, and to move to a place where they could "take the cure" of rest, fresh air, and a healthful diet.

When attempting to understand the history of medicine in the early twentieth–century, it is important to draw a distinction between what physicians knew about the mechanism of disease and how they applied that knowledge to treating patients.[2] With the rise of the laboratory sciences throughout the latter part of the nineteenth–century, significant breakthroughs were being made to explain the cause of the disease, but relatively little gain was made in terms of treatment. Prior to the bacteriological era, most physicians in the United States understood tuberculosis (or what they called *phthisis*) to be a noninfectious disease acquired as a result of hereditary predisposition

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[1] Betty MacDonald, *The Plague and I* (New York: J.B. Lippincott Company, 1948), 128.
[2] Clive Seale and Stephen Pattison, *Medical Knowledge: Doubt and Certainty* (London: Open University Press, 1994), 48.

and the environment (through vitiated air). But with the 1882 bacteriological findings of a German scientist named Robert Koch, American physicians of the early twentieth–century began to accept the theory that tuberculosis was caused by a microscopic organism, called the tubercle bacillus, which traveled from person to person.

Although empowered with knowledge of etiology, the medical community had no direct means to eradicate the newly discovered tubercle bacillus. In fact, up until mid–1940s, there were no known drug therapies that could consistently and effectively combat tuberculosis.[3] Pharmaceuticals from the pre–bacteriological era, such as cod liver oil and cresote, were discounted by most physicians of the early twentieth–century as remedies that magnified rather than alleviated the symptoms of tuberculosis.[4] Thus, throughout the first third of the twentieth–century, physicians mostly relied on noninvasive therapies, or what they saw as "the things [given by] nature," such as nutrition, rest and fresh air.[5] And the sanatoria were increasingly seen as the best places to administer this treatment regime.

The rationale behind the sanatorium regime went through many evolutionary stages between the nineteenth– and twentieth–centuries. The original sanatorium, founded by the German physician Herman Brehmer in 1854, was instituted on the belief

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[3] Streptomycin, discovered by Selman A. Waksman in 1943, was useful only up to a point, for the drug was limited because of adverse side–effects. While many were looking for the "magic bullet" throughout the early twentieth–century, medical researchers realized that waxy coating of the tuberculosis bacteria precluded a single drug treatment. Thus multiple drug therapy, using a combination of drugs, over a lengthy period of time is prescribed for today's cases of tuberculosis. In 1951, a synthetic drug known as isoniazid took the place of streptomycin. For more on the history of chemotherapy treatments for tuberculosis see Linda Bryder, *Below the Magic Mountain: A Social History of Tuberculosis in Twentieth–Century Britain* (Oxford: Clarendon Press, 1988), 253–265, as well as Seale and Pattison, 55–58.

[4] See Charles Rosenberg's discussion of "therapeutic nihilism" that became prevalent among many American physicians as well as the lay sector in the late nineteenth–century United States in *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: The University of Chicago Press, 1987), 223ff.

[5] Will Ross, *I Wanted to Live* (Milwaukee: Wisconsin Anti–Tuberculosis Association, 1953), 86.

that insufficient pulmonary circulation and poor general nutrition caused tuberculosis. Brehmer built his sanatorium in the Swiss Alps, for he believed that reduced atmospheric pressure would increase heart rate and metabolism, which would, in turn, increase pulmonary circulation. His sanatorium regime was based on diet, mountain air, and a careful balance between rest and exercise. Most importantly, rest was usually only prescribed when the patient was in a febrile state.[6] Edward Trudeau, a physician who suffered from tuberculosis himself, imported the sanatorium idea to America in 1885. He built the first sanatorium in America, situated in the remote mountainous Adirondack region of upstate New York. Although heavily influenced by Brehmer, Trudeau had different theories about disease causation and treatment, which ultimately formed his belief that rest should play a more dominant role in the American sanatorium than it did in Europe. By the 1920s and 1930s, some of the largest and most prominent sanatoria across the United States were adopting prolonged rest even for those patients who were asymptomatic. In fact, in certain sanatoria it became protocol to prescribe bed rest for up to three months for every newly admitted patient.[7]

From the perspective of physicians and researchers of the early twentieth–century, the claim that the cure for tuberculosis was "not medicine but a new regime of living" makes sense given the fact that, at that time, most pharmaceuticals (or "medicine") would only worsen the disease rather than help to cure it. But while knowledge of medical theories of disease–causation and treatment can illuminate the history behind the rise of the sanatoria movement of this century, it by no means gives us

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[6] R. Y. Keers, *Pulmonary Tuberculosis: A Journey down the Centuries* (London: Baillière Tindall, 1978), 76–77.

[7] Joseph H. Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," *The New England Journal of Medicine* 206 (1932): 68–69.

access to the whole story from all of the available perspectives. To provide a fuller account, we need to explore the accounts of patients who were treated in the sanatoria and ask such questions as: How did MacDonald herself understand the lesson in her rule book that stated that the cure for tuberculosis required a "new regime of living?" How did patients who were admitted to sanatoria across the United States perceive their illness and the prescribed treatment regime? And, above all, how did the treatment of prolonged bed rest, which became prominent in the American sanatoria, impact the patients who underwent it?

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Tuberculosis is a topic that has intrigued a wide–array of scholars in various times and places. It is a disease with a long history, dating back to Ancient Greece, and has probably been "responsible for more destruction of life and debilitation than any other infectious disease."[8] In the United States, for example, tuberculosis was the most common cause of death in the nineteenth–century, and continued to be one of the leading causes of death well into the twentieth–century. The disease had such a destructive presence that it was often called the "white plague," and the "captain of all these men of death."[9] Prior to Koch's discovery of the tubercle bacillus, the disease was most widely known among the lay population as "consumption," a term which vividly described the end stages of the disease when a patient's body would literally waste away. It was not until some sixty years after Koch's discovery, though, that an effective treatment for tuberculosis was found. The discovery of streptomycin in 1946, and the subsequent chemotherapeutic agent, isoniazid, greatly reduced the cases of tuberculosis in the United

[8] Seale and Pattison, 36.
[9] Rene and Jean Dubos, *The White Plague: Tuberculosis, Man and Society* (Boston: Little, Brown and Company, 1952), 3–10.

States by the mid–twentieth–century, which, in turn, led to the eventual demise of the sanatorium system.[10]

Most historical works about tuberculosis in the United States and Great Britain focus on the late nineteenth– and early twentieth–centuries, for this was a time of great change in science, medicine and social policies.[11] The discovery that tuberculosis was a contagious rather than an endemic disease caused by heredity and environment factors, led to widespread public health measures to control the spread of disease. For instance, by 1890, many of the temporary city and state public health departments which were concerned with broad environmental sanitation throughout the nineteenth–century, had become permanent structures, concerned with the individuals who harbored the deadly germs. No longer bound to broad notions of environmental causes of disease (such as miasma) and armed with laboratory tests, public health officials could pinpoint the cause of disease down to the very individual who carried the deadly germs. For public health officials, laboratory medicine thus offered a great deal of hope, for it was seen as a ticket to a better life and healthier society which would no longer be beset by the devastating diseases of the nineteenth–century. At a time in which tuberculosis was seen as "a source of inefficiency and waste, a brake on the progress of the nation," the optimism of the

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[10] It should be noted that this is only one interpretation of the history of tuberculosis and the sanatorium. As one of the few historians dealing with post war tuberculosis, Barron H. Lerner takes issue with this popular interpretation of the demise of tuberculosis and the sanatorium system. See Barron H. Lerner, *Contagion and Confinement: Controlling Tuberculosis along the Skid Road* (Baltimore: The Johns Hopkins University Press, 1998), 1–10. Using Seattle as a case study, Lerner demonstrates that during the post WWII years, "tuberculosis remained a major health problem, particularly in poor, urban communities." (Lerner, 4) In his view, the newly discovered streptomycin was not a panacea—the same social problems of poverty and noncompliance persisted throughout the 1950s and 1960s. As a result, Lerner demonstrates that Seattle authorities became particularly "zealous in its use of quarantine and detention" in the antibiotic era. (Lerner, 6)

[11] Lerner's book is an exception to this claim. Also Bryder dedicates a portion of a chapter in *Below the Magic Mountain* to the post–war therapies and their effects. See Bryder, 214–226.

laboratory sciences fueled grand–scale public health campaigns, and more specifically, anti–tuberculosis crusades, which sought to prevent the spread of the disease, with the ultimate goal of ushering in a new society of healthy citizens. [12]

In the initial years of the campaign, public health officials envisioned a two–pronged task force, which would lead the fight against tuberculosis. Public health departments essentially took on the task of disease prevention, while sanatoria adopted the goal of providing a cure for those already effected by the disease.[13] As for the task of disease prevention, several measures were employed, the first of which was tenement housing reform. But the measure of prevention that held the most promise (at least in the minds of that public health officials) was education. As Michael Teller writes, "the faith in the efficacy of education as a tool for social progress was widespread throughout the Progressive Era."[14] In movie houses, in the schools, and in the streets, pamphlets and posters were dispersed which advised the public to avoid spitting, always to cough in handkerchiefs, and to open windows for fresh air and sunlight. In fact, in some cases such advice eventually became law, with certain cities passing ordinances, which prohibited spitting in public places.[15] Overall, the main thrust of the educational campaign was to disabuse the public of its belief that tuberculosis was a hereditary disease—in order to control the spread of infection, the public had to understand its contagious nature.

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[12] Michael E. Teller, *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era* (New York: Greenwood Press, 1988), 33.
[13] Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: BasicBooks, 1994), 180.
[14] Teller, 56.
[15] Teller, 21.

As the campaign against tuberculosis progressed into the early decades of the twentieth–century, public health officials increasingly took on the role of the guardian to the greater health of the society, and thus wielded a great amount of power over individuals who were found to have tuberculosis. By 1904, mandatory registration of those who were sick was common in many cities. In effect, physicians were required by law to report the addresses of persons with tuberculosis so that a sanitary inspector (a representative of the board of public health) could visit the home of the infected person. The inspector would often provide the tubercular person with education pamphlets, and if the patient was in the advanced stages of the disease or understood to be harmful to the community, the inspector often had the "legislative, judicial, and executive powers" to forcibly confine the patient to a hospital or sanatorium.[16] Public health officials took on this power with the optimistic belief that nothing could stand in the way of their goal of eradicating the tubercle bacillus, not even the individual who carried the microbes. Narrowing their scope to the cellular level, public health officials tended to look past the particular individual with whom they were fighting. In their minds, one person's liberty was expendable if it meant eliminating disease. The equation was simple and utilitarian: isolate the deadly germs found in the one for the greater good of the many.

As the educational campaigns reached more people and as the trust in the laboratory sciences grew, so too did the fear of contagion. Much of the healthy populace became less tolerant of (and sometimes even hostile to) those with tuberculosis.[17] In fact by the early twentieth–century, the term *phthisiophobia* was used to describe the

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[16] Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston: Beacon Press, 1996), 42. The first mandatory testing for tuberculosis was instituted in New York City in 1897. (Teller, 22) By 1904, testing became a more widespread measure for tuberculosis prevention throughout the United States. (Rothman, 189)

[17] Rothman, 211–217.

increasing fear of tuberculosis.[18] For the patient, the diagnosis of tuberculosis was a kiss of death both physically and socially. Those with tuberculosis not only had to contend with the disease, but they also had to face the possibility of permanently losing their jobs, being separated from their families and communities, and confronting a potential life–time of stigmatization. Having tuberculosis at a time when society was largely driven by fear has led historians like Linda Bryder to conclude that "the social consequences of the disease were far worse than its physical manifestations."[19]

While public health officials were trying to locate new cases of tuberculosis in the hopes of preventing the spread of infection, physicians in the sanatoria were chasing the cure. Koch and other researchers were quick to point out that the emphasis on the bacillus as the sole and primary causative factor of the disease was wrongheaded, for although exposure was an important factor in disease causation, not everyone who was exposed to the bacillus developed the disease. Koch believed that secondary factors such as an individual's nutritional status, living conditions, and emotional state were very influential when it came to contracting tuberculosis. Following hard on the heels of Koch, Dr. William Osler argued in 1894 that "it was important to consider not only the seed (the bacillus) but also the soil (the patient) when analyzing why a given person had become tuberculous."[20] The sanatorium was thus largely concerned with the "the soil" half of the equation, for many physicians believed that a sufficiently well–rested, well–nourished, healthy person could resist the tubercle bacillus. Moreover, many in the medical field thought that the typical sanatoria regime could not only aid the already

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[18] Rothman, 190. *Phthisis*, a Latin word meaning the wasting away of a body part, was often used by physicians prior to Koch as a diagnostic term for tuberculosis of the lungs.
[19] Bryder, 5–6.
[20] Lerner, 2.

healthy in warding off the tubercle bacillus, but, more importantly, it would help already active tubercular patients to become well again.

Although the initial sanatorium movement during the bacteriological era was primarily instituted for the purpose of delivering a cure, by 1910 many sanatoria increasingly adopted the goal of prevention.[21] As the fear of contagion grew in the twentieth–century, sanatoria, which were originally erected in remote locations for the goal of providing fresh air, were increasingly seen as prime locations for quarantine, where the tuberculosis patients could be isolated from the rest of society. With the goal of prevention, sanatoria across the United States began to institute strict rules and regulations for its patients with the goal of trying to shape the patient's behaviors and habits—they became places of strict education, where it was thought that patients who had early stage tuberculosis could be taught how to avoid spreading their disease.

In addition, unlike the early sanatoria, which readily accepted advanced cases of tuberculosis, the sanatoria of the late 1910s and early 1920s began favoring admission of early (incipient) cases of tuberculosis. There was a two–fold rationale for this change in admissions policy. First, medical officials thought that people who had incipient tuberculosis posed a greater threat to society than the advanced cases. That is, they believed that the people who had initial stages of tuberculosis and thus *felt* healthy posed more of a problem because these healthy carriers would not believe that they *were* sick. Medical officials worried that asymptomatic carriers would more likely be careless, and

[21] Lerner, 25. In fact, according to Lerner, the Sixth International Congress of Tuberculosis in 1908 encouraged sanatoria to take a more active role in the efforts of isolation and education in order to better control the spread of the contagion.

not take the necessary precautions to prevent the spread of disease.[22] Second, early studies regarding the effectiveness of the sanatorium regime revealed that the highest cure rates were among those who were in the early stages of the disease and that the sanatorium had little–to–no effect on those who were admitted with moderate or advances cases of the disease.[23] So the sanatorium officials turned their attention toward what they perceived to the more menacing yet hopeful cases of tuberculosis.

Along with the shifts in goals and patient populations, twentieth–century sanatoria began to differ from the earlier sanatoria in treatment protocol, emphasizing complete bed rest rather than promoting a balance between inactivity and exercise.[24] Many of the sanatoria in the initial years of the bacteriological era varied in their treatment philosophies, especially concerning the issue of physical activity. Although most medical directors prescribed rest for the initial week of a patient's stay, there was little consensus about how much physical activity a patient should be allowed to perform.

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[22] For more on why public health officials in the early twentieth–century viewed healthy carriers as great threats to society, see Leavitt, 35ff.

[23] For more, see Teller, 85–90 and Lerner, 22–30. Teller provides some interesting statistical evidence that the medical community of the early twentieth–century used to assess the effectiveness of the early sanatoria. For instance a study performed at the Mont Alto Pennsylvania State Sanatorium in 1916 showed that out of 1,567 incipient cases, 261 were considered cured, 558 "arrested," 595 improved, 120 unimproved and 3 dead. (Teller, 83) In addition, a longitudinal study was performed by the New York Loomis sanatorium in 1911 in which medical officials surveyed the physical health of patients who were discharged from their sanatorium between the years 1902–1905. Out of the 547 patients discharged, 61 percent had died. Out of those 61 percent who had died, 17 percent were considered cured upon discharge between 1902–1905, while 51 percent were considered arrested, and 72 percent improved. (Teller, 89)

[24] Bryder, 184–188. Bryder offers a different interpretation about the rise in rest therapy than the one I advocate in this thesis. According to Bryder, the rise of the use of rest therapy can be traced to the burgeoning field of surgery early in the twentieth–century. Given the fact that prior to the 1940s there were no drug therapies that could successfully eradicate the bacillus, surgical procedures, which were believed to hasten recovery, flourished in the sanatoria. Writing primarily about the British sanatorium system, Bryder argues that as the use of surgical procedures increased, so too did the order for rest. Eventually, according to Bryder, "rest was...prescribed even when surgery was not involved." (Bryder, 184) But in the United States, rest therapy was being advocated as a good in itself, regardless of surgery.

Some physicians adhered to the rule that a patient should rest only if he or she had a fever, and that graduated exercise was the most beneficial treatment for those who were asymptomatic. Other physicians, such as Dr. Alfred Loomis of New York and Dr. Marcus Paterson (a prominent physician of the sanatoria system in Great Britain) advocated work therapy, believing that a patient's resistance was actually boosted by heavy manual labor.[25] But by the 1920s, a very prominent American physician named Joseph Pratt began to persuade many of the sanatorium doctors that complete bed rest, twenty–four hours a day for several months was a more effective treatment than work therapy or only minimal rest.[26] Pratt's prescription for prolonged rest included even those patients who were asymptomatic. Many sanatorium physicians and medical directors followed in Pratt's footsteps. For example, in 1922, Dr. Ernest Emerson who directed the Rutland State Sanatorium in Massachusetts was prescribing a minimum four

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[25] See Bryder, 184–188 and Keers, 90–94. Physicians in Great Britain believed that there was much value in having sanatorium patients perform heavy manual labor. The work therapy protocol required, for example, that patients be able to walk ten miles carrying spades and shovels for digging. (Keers, 94) Many were convinced that work therapy had both social and physiological benefits. First, many believed that work therapy was a good way to reinforce the work ethic in the working classes. (Seale and Pattison, 50) In addition, following the work of Marcus Paterson, many physicians held the view that through heavy labor, patients could release their own tuberculin, a chemical byproduct which naturally increased their resistance to tuberculosis (a view which later became known as the auto-inoculation theory). (Keers, 94) In comparison to Britain, American physicians did not have the same enthusiasm for work therapy. Bryder suggests that American physicians may have upheld the rest therapy due to the competitive open marketplace. That is, more American doctors were concerned about their professional status and thus promoted rest rather than work—a line of thinking based on the assumption that patients would be more likely to accept rest and reject work. (Bryder, 186) While the marketplace may have been a contributing factor, it does not account for the increasing amounts of evidence that American physicians used to show that benefits of rest over work. Nor does the marketplace argument take into account the social–cultural background of American medicine during the nineteenth–century when consumption was treated primarily through rugged, outdoor living. (Rothman, 131–161) That is, in America during the twentieth–century, the consensus about the benefits of rest might have been a reaction against the failed nineteenth–century prescriptions of extreme amounts of activity.

[26] In 1923, Clive Riviere performed a study comparing the rest therapy as practiced by Pratt, and the work therapy advocated by Paterson. Riviere concluded that rest therapy was superior. For more on this, see Keers, 95.

months of rest for all sanatorium patients. And by the 1930s statistical evidence was available which showed that patients (especially those with incipient cases) who underwent the rest cure had higher cure rates than those who underwent work therapy.[27] With such promising results, prolonged, complete bed rest eventually became the dominant therapy of the American sanatoria.[28]

Confined to their beds for long periods of time, the patients who were admitted to the sanatoria across the United States between the years of 1910 and 1940 had an experience which was different from their predecessors or European counterparts who were allowed to engage in moderate physical activity. The turn toward prolonged rest therapy changed the image of American sanatoria. As Frank Ryan recounts,

> The basic remedy was 'bed rest' in its most stringent form: 24 hours flat. Meals were spooned to each patient by registered nurses, bed baths and the universal bedpans were imposed on those...who looked and felt normal but who had shadows—even small shadows—on their chest X–ray.[29]

Even those patients who were able–bodied enough to walk up to the institution's doors would not make physical contact with floor again until they had undergone months of complete bed rest.[30]

This project is an account of what it was like to live in the American sanatoria during the time period in which prolonged rest became the dominant therapy. As such, this study's primary focus is on the patient's point–of–view. Its goal is to show how

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[27] Joseph Pratt, "The Evolution of the Rest Treatment of Pulmonary Tuberculosis," *The American Review of Tuberculosis* 50 (1944): 196. The sanatorium regime was never subjected to a large scale scientific trial to test its effectiveness, so the records of how many patients actually benefited from the sanatorium treatment are scant. But a more thorough investigation might be able to further substantiate this point.

[28] See Teller, 25 and Keers, 94.

[29] Frank Ryan, *The Forgotten Plague: How the Battle Against Tuberculosis was Won—and Lost* (Boston: Little, Brown and Company, 1993), 27.

[30] For instance, MacDonald did not receive ambulatory privileges until 3 months after her admission to the sanatorium. See MacDonald, 138.

patients who, for most part asymptomatic, experienced and endured their lot as patients under the sanatorium regime; it explores the thoughts and emotions that they had as subjects who were primarily confined to their beds, and relegated to a life of extreme passivity. This study will map their experiences, explaining how they classified their illness, how they reflected upon living in such confined quarters, and how they organized reality. I will examine these patients' hopes and feelings, to show not only what they thought but how they thought. [31]

In this study, I argue that the rest therapy common to the American sanatoria during the years of 1910–1940 had a great effect on the patients' mental lives. Although the prescription for rest was not physically invasive, it was psychically invasive. Sanatorium patients paid a very high price for the hopes of a cure, that was unfortunately rarely realized. They gave up their means of livelihood and left their families and friends to live in the confines of the sanatorium. Cut–off from the outside world, they were left with little to do but to "take the cure." Most importantly, the sedentary lifestyle of the rest cure promoted a deep feeling of isolation and alienation from the outside world. Indeed, this alienation ran so deep that the patients began to perceive space, time and their life plans (teleology) differently from when they were healthy.

In some respects, this project takes some initial steps towards filling a gap found in the current historical literature relating to the topic of medicine. As historian Roy

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[31] Taking this approach to the sanatorium narratives, I have been influenced by two historians who claim to practice what they call "microhistory." For instance see Robert Darnton, *The Great Cat Massacre: And Other Episodes in French Cultural History* (New York: Vintage Books, 1984), 3–4; as well as Natalie Zemon Davis, *The Return of Martin Guerre* (Cambridge: Harvard University Press, 1983), 1–3. My understanding of microhistory has also been informed by Peter Burke, ed., *New Perspectives on Historical Writing* (University Park: The Pennsylvania State University Press, 1991), 1–23, 93–113.

Porter has pointed out, "we lack a historical atlas of sickness experience."[32] Porter invites scholars to engage in a study of the sufferers' role in history, to "lower the historical gaze onto the sufferers," to explore the other half of the doctor–patient relationship.[33] Porter is responding to a tradition of medical history in which the experiences of ordinary men and women had often been ignored. Prior to the 1970s, the story of medicine was primarily understood to be one of triumph, of new discoveries and conquests, with physicians as the pivotal figures around which history revolved.[34] Answering Porter's call, this project will take a step toward moving the patients to the center of the story alongside the physicians.[35]

This project, however, is not the first account of the experience of tuberculosis from the patient's perspective. Several scholars have studied narratives of those who had tuberculosis in order to inform us about the devastating effects that the public health movement and the sanatoria had on many patients' lives. For example, in *Below the Magic Mountain*, a book that recounts the anti–tuberculosis campaign in Great Britain, Bryder dedicates a chapter solely to the patients' view. In it, she discusses the widespread stigmatization with which tuberculosis victims had to contend, and she argues that the sanatoria of the twentieth–century should be thought of as "total institutions," where patients were isolated from the rest of society "both geographically and socially."[36]

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[32] Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14 (1985): 192.
[33] Porter, 192.
[34] E. Richard Brown, *Rockefeller Medicine Men: Medicine & Capitalism in America* (Berkeley: University of California Press, 1979), xi. See also Susan Reverby and David Rosner, ed., *Health Care in America: Essays in Social History* (Philadelphia: Temple University Press, 1979), 3–4.
[35] Rothman, 3.
[36] Bryder, 200. Bryder gets the idea of total institution from Erving Goffman's work on asylums.

Using patients narratives, Bryder points out that some patients were treated as social pariahs among their own families and, on the whole, shunned by the larger society.

Moreover, in her book, *Living in the Shadow of Death*, which explores how the experience of having tuberculosis in America changed from the early nineteenth–century to the twentieth–century sanatoria, Sheila Rothman gives an account of the sanatorium experience that is very similar to Bryder's. Rothman even equates the "total institution" of the sanatorium to the "total institution" of prisons. And she draws this conclusion directly from the patient narratives. As she writes, "to see the sanatorium from the inside, from the perspective of the patient, is to see it in the first instance as an incarcerative institution."[37] Rothman convincingly demonstrates the many ways in which sanatorium life was like a prison by primarily focusing on the patients' discussions of the sanatorium admissions process, a time in which patients were treated according to the strictest of protocols. For instance, following the rule book initiation, patients were often scrubbed, stripped of many of their personal belongings (such as photographs, personal medications, etc.) and escorted, usually by wheelchair, to a room, which they were made to share with other patients.[38]

To be sure, thinking of the twentieth–century sanatoria as a "total institution" is a helpful step toward understanding that patients were confined not only to a building, but also to a "sick role" in which they had to adopt the sanatorium rules and regulations, and stop living lives like healthy people would. But unlike Rothman and Bryder, I wish to

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[37] Rothman, 227. Rothman rightly points out that historians were by no means the first to make the prison analogy, for many of the patients themselves write that they were treated like prisoners. In doing so, she centers much of her discussion on patients like Marshall McClintock, who after receiving his rule book, claimed "I felt worse than ever. Like a prisoner." See Marshall McClintock, *We Take to Bed* (New York: Jonathan Cape & Harrison Smith, 1931), 145.
[38] Rothman 227–234.

shift the focus of the discussion to the rest cure. Prolonged bed rest was a therapy unique to the American sanatorium regime of the early twentieth–century, and as such, it greatly defined the perspectives of those who wrote about their experience.[39] A closer study of the sanatorium patients' day–to–day experiences, confined to bed, will reveal an even deeper level of felt isolation, one that pervaded their daily thoughts, and shaped their experience of reality. Looking at the narratives in this light, one can see the deleterious effects that prolonged rest had on the patients' psyches.

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This study focuses on five people, all of whom were patients of the sanatorium system and authors of their own autobiographies. All of these subjects were in the sanatorium at a time in which the prolonged rest was used a therapeutic modality, and all appear to have had incipient cases of tuberculosis.[40] However, they underwent their sanatorium stays in various parts of the United States. For instance, Isabel Smith, who

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[39] Prolonged bed rest is one important facet of the American sanatorium experience that Rothman does not explore. Rothman claims that there was little consensus about how much rest and exercise should be prescribed in the sanatorium. (Rothman, 206–207) But this was only true for the first decade or so of the twentieth–century, for a significant amount of evidence suggests that by the 1920s there was a growing consensus about the benefits of prolonged rest therapy throughout the United States. Moreover, the fact that prolonged bed rest became a dominant therapy in America sanatoria is a crucial element in interpreting the narratives that Rothman uses, for a large majority of them were written in 1920s, 1930s and 1940s and their authors write about the experience of being confined to bed for long periods of time.

[40] Some of the narratives do not provide a clear timeline of their sanatorium experience. Will Ross' autobiography appears to be the earliest narrative. Based on the diagnostic tools that Ross claims were used in his sanatorium (i.e. no X–ray diagnostics), I am inferring that he was in a sanatorium sometime between 1910–1920. Likewise, Sadie Fuller Seagrave's narrative also gives no definite timeline, but I am assuming that she was in the sanatorium sometime prior to 1920. See Sadie Fuller Seagrave, *Saints' Rest* (St Louis: C.V. Mosby Company, 1918). Both MacDonald and McClintock appear to have been in the sanatorium during the 1930s. Lastly, Isabel Smith was admitted in 1928 and underwent the longest stay out of the five autobiographers. Smith was not released from Saranac sanatorium until 1949, when she received chemotherapy treatment which cured her tuberculosis. Nevertheless, most of Smith's autobiography takes place between the years of 1928–1940. See Isabel Smith, *Wish I Might* (New York: Harper & Brothers, Publishers, 1955), xi, 213.

was diagnosed with tuberculosis while she was undergoing nurse's training in New York City, was sent to the Saranac sanatorium system in upstate New York. Like Smith, Marshall McClintock, who writes of both he and his wife's experience with tuberculosis, gave up his career in Cleveland, Ohio at the advice of his physician, to move his entire family (he had one son) to Saranac.[41] On the West Coast, MacDonald, a single mother of two children, gave up her job as a secretary in a governmental agency to enter a charitable state–run sanatorium just outside of Seattle, Washington. The final two patients whom I examine come from the Midwest. Sadie Seagrave was admitted to a state–run sanatorium in Iowa and Will Ross was a patient at a sanatorium in Stevens Point, Wisconsin.[42] These patients came from different walks of life: some were married, others were single, some had children, others did not. All of them, however, were fairly well educated and apparently working middle class.[43]

Recounting the story of the patients who underwent the sanatorium regime of the early twentieth–century brings with it some unique challenges, especially in trying to reconstruct the patients' worldview. For instance, what did these patients take to be the

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[41] McClintock, 6–16.

[42] Seagrave does not reveal the specific location of the sanatorium in which she stayed. It seems probable that she was in a sanatorium in Iowa. See Seagrave, 12. Rothman supports this conclusion that Seagrave was treated at a state–run Midwest sanatorium. See Rothman, 231.

[43] It should be noted that this study only tells a story of a very specific group of people, namely that of white, middle class tuberculosis sufferers. However, it should be kept in mind that the sanatorium experience in the United States did differ according to class and race. For instance, those who could not afford private sanatoriums were often sent to overcrowded, urban, city–run facilities. For more on this, see Rothman, 185–193. According to Barbara Bates, black Americans who had tuberculosis and were admitted to a sanatorium suffered from higher death rates than white Americans. In addition, black Americans encountered a more hostile environment in the sanatorium than their white counterparts. While relatively little is written about the American black experience in the sanatorium, Bates, in a chapter entitled "P.S. I Am...Colored," provides a very insightful discussion about how the Pennsylvania sanatorium system treated African Americans with tuberculosis. See Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876–1938* (Philadelphia: University of Pennsylvania Press, 1992), 288–310.

causative factor of their disease? Why did they agree to go to a sanatorium in the first place? Moreover, given the rigid therapeutic regime in the sanatorium, and the fact that many of these patients were asymptomatic and therefore felt well, why did they stay?

Several of the narratives suggest that the patients' understanding of tuberculosis was informed by both humoral and bacteriological theories. Some, like MacDonald admit to knowing very little about the disease. She writes, "I was almost thirty years old,...but what I knew about tuberculosis, its symptoms, its cause and its cure, could have been written on the head of a pin."[44] Although MacDonald grew up in a family that believed that family history was the most important factor in disease causation, to a certain extent, she was aware of the contagious nature of the disease. She recalls going to movies and seeing public health announcements that counseled good hand washing, and advised the public to cough into handkerchiefs so as to prevent the spread of contagious diseases like tuberculosis.[45] Still, almost every autobiography used in this study opens with a detailed account of the narrator's medial history, including his or her own believed hereditary and constitutional predispositions to getting tuberculosis. For example, Ross talks about how his mother had difficulty accepting the fact that her son had tuberculosis. Ross quotes her saying, " I just can't see how it happened...There's never been a single soul on either side of the family so far as I know that ever had tuberculosis. Why should it pick on you?"[46] That tuberculosis was caused by hereditary factors was still a widely held belief in the early twentieth–century. In fact, even up until a 1939, when the public's understanding of tuberculosis was first measure by a Gallup poll, 50 percent of

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[44] MacDonald, 31.
[45] MacDonald, 17–19, 31.
[46] Ross, 1–2.

those polled still thought that tuberculosis was inherited by birth, and 25 percent did not know that it was contagious.[47]

In all likelihood, the public of the early twentieth–century was confused by rapidly changing scientific discoveries; many lay people were probably not certain about the mode of infection, or the best methods of treatment.[48] Some may have willingly gone to the sanatorium because it was the best hope for a cure.[49] Or for those who understood the contagious nature of tuberculosis, perhaps they went to the sanatorium so as to protect their family and loved ones. To be sure, many patients did not want to go to the sanatorium. And a significant number of patients left the sanatorium against medical advice within the first few months of arrival.[50] But as the fear of contagion grew within the larger society and the public became more hostile to those with tuberculosis, many patients may have wanted to go to a place, like the sanatorium, where people would be more accepting of their disease.[51]

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In order to set the stage of sanatorium living, I begin this project with a brief history of the sanatorium system. In chapter 1, I will explore more fully the medical rationales behind the sanatorium regime of rest, diet and fresh air, many of which had their roots in the pre–bacteriological era. More specifically, I will discuss several reasons why the rest cure was so appealing to American physicians.

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[47] Teller, 63.
[48] Teller, 57.
[49] In a 1939 Gallup poll, 86 percent of those polled believed that tuberculosis was a curable disease. See Teller, 63.
[50] For instance, according to Lerner, at the Firland sanatorium in 1916, 69 patients out of a total of 96 were discharged against medical advice. (Lerner, 29) Likewise, Rothman claims "anywhere from 10–30 percent of sanatorium patients left within a month of arrival." (Rothman, 245)
[51] Rothman makes this suggestion. See Rothman, 217.

After this introduction to the typical sanatorium regimen, the subsequent three chapters explore how the patients reacted to this "new regime of living." In chapter 2, I examine the subjective side of the experience of confinement more deeply than it has been in the existing historical literature. In describing the sanatorium as a place of total confinement, previous historians have focused on the physical location and structure of the institution, as well as the sanatorium personnel and rules which greatly restricted patients' personal autonomy and freedom. But keeping in mind the predominance of prolonged rest in the American sanatoria, I will push the discussion of confinement further, highlighting what the patients themselves thought of as the most immediate barriers of their freedom—those of the room, bed, and the body.

Indeed, relegated to a singular bed, sanatorium patients experienced a kind of encroachment of physical space. Indisputably their experience of "objective" space was one of confinement and constriction; that is, the physical, measurable, three–dimensional space in which they could move about was extremely small. However, as is evinced by their narratives, patients experienced space not merely in objective terms, but also as perceiving subjects. For example, conceiving of space in a more metaphorical way, many patients claim that they felt that the "outside," everyday world (which may have physically only been a very short distance from the sanatorium walls) stood at a great distance from the sanatorium world which they inhabited. In fact, some patients claim that the distance between themselves and their family grew to such an extent that they eventually felt like foreigners among their next–of–kin. In addition, living a daily life in a horizontal position, some patients indicate that their sense of spatial dimensions had

radically altered—that measurably short distances felt larger than what they were, objectively speaking.

Thus chapter 2 will demonstrate that, from the patient's point of view, objective and subjective space were inversely proportional in the sanatorium—as objective, physical boundaries constricted, the subjective experience of space expanded. In a way, it was as if sanatorium patients experienced the opposite phenomenon of what certain people today call the "shrinking world." That is, unlike those who claim that through modern technology (like air travel and the Internet) the globe *feels* smaller than it did a century ago, sanatorium patients experienced a kind of spatial expansion, for as they continued to live in a state of confinement, they conceived of travel through relatively small distances to be very difficult. Almost anything or anyone who existed beyond their beds exceeded their grasp. To be sure, the actual size of the sanatorium or the "outside" world had not changed, but their subjective sense of the matter told them that as their days in the sanatorium accumulated, so too did the distance between themselves and their homes, families and friends.

Continuing to explore the effects of physical confinement on patients' subjective experience of their sanatorium stay, in chapter 3 I discuss how confinement effected the patients' abilities to make life plans. As we shall see, for a large part of their sanatorium stay, the patients in this study all claimed to have felt well. This state of wellness often allowed them to dream of their futures, of returning home, of pursuing their careers, or of having a family. For, subjectively speaking, they felt well enough to accomplish these goals. But despite their sense of well being, they were physically confined and not able to act toward accomplishing their goals. Thus what precluding these patients from

realizing their life plans was not necessarily a grave state of sickness which was directly impeding action, but rather a medical society which, in deeming them sick, confined these patients to bed despite their subjective sense of well–being. I will argue that ultimately this sense of well–being coupled with confinement to bed resulted in a kind of a "teleological constriction," for the only tangible and meaningful goal towards which these patients could aim was discharge from the sanatorium. It was only after shedding their sick roles as patients that they could resume the common teleological drives of healthy persons.

Finally, in chapter 4, I address the influence that sanatorium confinement and the phenomenon of teleological constriction had on the patients' experience of time. In a confined space, cut–off from the "outside" world, sanatorium patients write about the feeling of losing touch with objective, measurable time. Thus, the patients' days, weeks and years were mostly dominated by a subjective sense of time—sometimes time would seem slow, at other times fast. Moreover, I will argue that because of sanatorium confinement, the passage of time became a dominant theme of many patients' thoughts. For some, time was the enemy, for they felt that they had too much "time to kill." To make matters worse, most patients had no sense about how long they would have to stay in the sanatorium. Physicians, who were unsure of patient prognoses themselves, would rarely discuss with their patients the projected date of discharge. Hence the patients' one teleological goal of discharge was quite opaque at best, and it is for this reason that many patients became obsessed with the passage of time, for none of them knew how long it would be until they would be able to return to their former lives in the outside world.

In trying to elucidate the patients' experience of time, I rely on Thomas Mann's novel *The Magic Mountain* to supplement my interpretations of the patient narratives. Although both Rothman and Bryder point to Mann's novel as a perpetuator of false conceptions about the sanatorium experience, it appears that, in regard to the particular facet of subjective time experience, there is quite a bit of agreement between what Mann writes and the narratives of American tuberculosis patients. While one should always use caution in employing fiction to describe a real situation, Mann's novel is nevertheless located in the very real circumstances of the sanatorium, and there are thus certain aspects of the novel which can be helpful in historical interpretation.[52]

In all, this project explores how the given context of the twentieth–century sanatorium and the predominant therapy of prolonged bed rest effected the patients who endured it. Although the topic is narrowly focused on a particular time and a certain patient population, I intend my readership to be broad. For not only will this project add to the historical literature which already addresses the sanatoria of the early twentieth–century, but it will also speak to current debates regarding the definitions of disease (specifically those of a chronic nature) as well as the experience of sickness. For the most part, the total confinement to the sanatorium molded the experience of those who had tuberculosis in the early twentieth–century. As a work which primarily focuses on the theme of the experience of sickness at a given point in history, this project will not provide a definitive theory about the experience of sickness as such, nor will it be a history about the rise or the triumph of the medical sciences. Rather it is story of ordinary men and women whose stories reveal the cost that was paid for the hopes of a cure.

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[52] I would like to thank Steve Rachman for making this point clear to me.

CHAPTER 1
THE TRIUMVIRATE: REST, FOOD AND FRESH AIR

By the early twentieth–century, American physicians increasingly began to prescribe a sanatorium regime of rest, diet and fresh air for their patients with tuberculosis. In doing so, they rejected the common nineteenth–century therapy of traveling to the Western plains of the United States and working the land as a means to attain health. While the therapies of rest, diet and fresh air were rooted in a long tradition of Western medicine, American physicians of the twentieth–century shaped the regime in their own image and, most importantly for this discussion, radicalized the rest treatment. The shift in the medical profession away from exercise toward the prescription of rest occurred due to a variety of factors, among the most important of which was Koch's discovery of the contagious nature of tuberculosis as well as his influential notion of disease "resistance," a theory which prominent American physicians used to validate the move toward prolonged bed rest in American sanatoria. [53]

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The prescription of rest and a diet of milk for tuberculosis can be traced back to Galen who understood the disease to be a complication arising from the inflammatory

[53] This chapter by no means touches on all of the possible socio–cultural reasons why the rest therapy became a predominate part of the American sanatorium regime of the twentieth–century. A more in–depth study of this shift would certainly take account of economic forces which may have influenced many physicians. For more information about market forces and physicians at the turn of the twentieth–century, see Brown, 60–132. In addition, one would need to look more closely at the fact that physicians of the early twentieth–century were vying for more power over their patients. Rothman discusses this point in terms of a shift in the doctor–patient relationship between the nineteenth–and twentieth–century. That is, in the nineteenth–century, physicians and their patients enjoyed a more fluid relationship, for patients were understood to be essential to the medical decision making process. But in the twentieth–century, with the rise of laboratory medicine, treatment decisions were made solely by the doctor, and patients were expected to comply. See Rothman, 179–252. Thus, from the physicians' perspective, the sanatorium and its requirement that patients stay in bed may have seemed like the perfect combination of institution and practice with which to wield a great deal of power over their patients.

conditions associated with advanced forms of fever. More specifically, he understood pulmonary tuberculosis to be an ulceration of the lung. Reasoning from analogy, Galen thought "pulmonary ulceration demanded therapy similar to that employed to heal ulcers of the body surface." Yet the medication for the lung had to be something that could be ingested.[54] And apparently Galen thought that fresh milk was the best remedy for such pulmonary ulcers. Along with milk, Galen was an advocate of inactivity, prescribing "rest, restraint of cough and...a ban on visitors to eliminate the strain of conversation."[55]

The Galenic model of treatment persisted in Europe throughout the following centuries to greater and lesser degrees. For the most part, his dietetic regime was followed for many centuries. But his theory of rest fell out of vogue in the seventeenth–century, when exercise, such as horseback riding, was frequently prescribed. And in the eighteenth–century, certain physicians advised tuberculosis patients to take up residence in the country and to perform light work in gardens. By the nineteenth–century, however, it became common to prescribe extended stays in closed, dark rooms and to insist that the patient eat only very light, meat–free diets.[56] At this time, clinicians also began to formulate treatment regimes according to disease stages. Working from the notion that tuberculosis was an "irritant" which should be treated by "counter–irritants," many physicians treated the initial "inflammatory" phase with an anti–inflammatory regime of blistering, vomiting, purging and bleeding and the advanced stage of "ulceration" with balsams and expectorants.[57]

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[54] Keers, 15. For more on Galen's theory of tuberculosis, see Seale and Pattison, 40.
[55] Keers, 15.
[56] For more on the history of therapeutics for tuberculosis see Keers, 65–78, as well as Seale and Pattison, 40–44.
[57] For more on the "irritant–counterirritant" theory see Charles Rosenberg and Morris J. Vogel, ed., *The Therapeutic Revolution* (Philadelphia: University of Pennsylvania Press, 1979), 5–11.

Several notable physicians in the nineteenth–century opposed the common–day treatments of bleeding and purging, and in doing so, they significantly influenced the later sanatorium regimes of Brehmer and his successors. For example, writing an essay on the treatment of pulmonary tuberculosis in 1840, Dr. George Bodington of Britain argued that fresh, cold air was a better (and perhaps more humane) remedy than the common counterirritants of such as digitalis, various emetics and shutting people in closed, windowless rooms. He writes, "The application of cold pure air to the interior surface of the lungs is the most powerful sedative that can be applied, and does more to promote the healing and closing of cavities and ulcers of the lungs than any other means that can be employed."[58] Bodington's belief in the sedative effects of fresh air was well received, for it was innocuous in comparison to the harsher pharmaceuticals of the day. His treatment, however, was not completely benign, for in his mind, the colder the air, the better. According to Bodington, "the cold is never too severe for the consumptive patient...the cooler the air which passes into the lungs, the greater will be the benefit the patient will derive. Sharp frosty days in the winter season are most favorable."[59]

Another opponent of the overenthusiastic use of counterirritants of the nineteenth–century was John Hughs Bennett of Edinburgh who believed that pulmonary tuberculosis was caused "impoverishment of the blood," and "exudations into the lung."[60] Thus Bennett believed that a diet high in fat was essential for nourishing the blood and preventing further ulceration of the lungs. At the same time in France, S. Jaccoud who studied medical pathology, argued for the therapeutic value of milk. Also believing that

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[58] George Bodington, *An Essay on the Treatment and Cure of Pulmonary Consumption* (London: Simpkin, Marshall, Hamilton & Kent,1840), 16–17, quoted in Keers, 68–69.
[59] Bodington, 16–17, quoted in Keers, 68–69.
[60] J.H. Bennett, *The Pathology and Treatment of Pulmonary Tuberculosis* (Edinburgh: Sutherland and Knox, 1853), 82 quoted in Keers, 71–72.

an increase in blood flow would help the tubercular patient, he maintained that milk could work toward "diminishing the frequency and intensity of the cough, and after a time has undoubtedly a sedative effect upon nervous and vascular excitability."[61] Jaccoud also upheld the recommendation of rest and fresh air and felt that they were perfectly compatible with his recommendation of drinking milk.

It is out of this long and rather complex tradition of therapeutics in the West that Brehmer's idea of the sanatorium arose. Unique to Brehmer was his insistence that tuberculosis patients should live at high altitudes, for he believed that their metabolism and circulation would increase once they were exposed to lower atmospheric pressure. Believing that tuberculosis was primarily caused by poor circulation to the lungs, Brehmer thought that a patient's metabolism was further enhanced with a plentiful diet and graduated exercise. In his mind, complete rest was only suitable for patients who were febrile. However, rest became a more predominant part of Brehmer's system when his physician–patient, Peter Dettweiler, developed the concept of reclining cure chairs, which were portable chaise lounges that could be used outdoors in protected verandas. Although Dettweiler primarily developed the cure chair idea so that patients could benefit from longer periods of fresh air, the fact that patients were ordered to remain in a chair several hours a day meant that the sanatorium lifestyle became more sedentary by default.[62]

At the time that the sanatorium idea was first introduced to the United States in the 1880s, many American physicians were still prescribing travel as a means to combat

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[61] S. Jaccoud, *The Curability and Treatment of Pulmonary Phthisis* (London: Kegan Paul, Trench & Co., 1855), 190, quoted in Keers, 74–75.

[62] For more details on Brehmer's sanatorium regime, see Rothman 194–195, Keers, 76–77 and Pratt, 1932, 64–65

tuberculosis. Until the sanatorium gained ascendancy, many tubercular men who lived in the cold, dank, wet environment of New England traveled to more health–conducive (often warmer, dryer) climates and labored in the open air. Early in the nineteenth–century, many men went on sea voyages to improve their health. But as the century progressed, many consumptives, known as "health–seekers," traveled West to the open plains to live a more rugged life of riding horseback, eating buffalo meat and sleeping outside in the open air.[63]

It was in era of "health–seekers" that Dr. Francis Trudeau built the first American sanatorium and Dr. Paul Kretzschmar, a patient of Dettweiler's, delivered several papers advocating the Brehmer–Dettweiler sanatorium system. Kretzschmar adamantly opposed the America prescription of out–of–door living. First, he argued that to promote a life outdoors among other healthy people, was to disregard Koch's new theory of contagion. Allowing Americans to travel freely from state–to–state meant that the contagion traveled with them which increased the potential spread of disease. Second, he thought that American physicians who allowed their patients to perform heavy labor ignored the important relationship between the disease and lowered resistance. Following Koch's theory of resistance, Kretzschmar believed that the sanatorium regime of rest was better at strengthening the patient so that she could resist the bacillus. Finally, in advocating the Brehmer–Dettweiler regime, Kretzschmar maintained that patients required physician supervision in order to get well.[64]

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[63] For more on sea–voyagers and health–seekers who traveled West, see Rothman, 13–57, 131–161.

[64] Much of the information and interpretation of Kretzschmar's arguments come from Rothman, 196–198.

Similar in thinking to Kretzschmar, Trudeau built the first American sanatorium system in Saranac, New York, based on the belief the best treatment for tuberculosis required improving a patient's resistance through an abundance of food, invigorating climate and rest. Trudeau did not prescribe prolonged bed rest, however. Rather, he maintained that a balance of light exercise and rest was the best remedy for a cure, especially for those patients who had "inactive" cases of tuberculosis. Nevertheless, when compared to his European predecessors of Brehmer and Dettweiler, Trudeau was much more cautious about prescribing exercise. In a letter to a fellow physician, Trudeau is quoted as saying, "the fact still remains that when a tuberculosis process shows any degree of activity, rest is the safest plan to follow. I know I have hurt nobody by rest, but I am quite sure I often have by allowing them to exercise."[65] Trudeau thought he had learned some important lessons about rest from the new surgical techniques of the day. At an Association of American Physicians in 1900, he delivered a paper in which he said, "Surgery has taught us that activity of a part affected with tuberculosis always tends to aggravate the disease and render it progressive. A tuberculous joint may often be cured by simple immobilization, while it will go on to destruction if the patients be allowed to use it at will."[66] For Trudeau, rest was the safer route to take so as to avoid any aggravation of a patient's condition.

Although the amount of activity that a tuberculous patient should undertake was a subject of dispute among American physicians around the turn of the twentieth–century, several prominent physicians came to a consensus by the 1920s that prolonged rest was

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[65] This is how Pratt recounts the words of a letter that Trudeau sent to Pratt in 1900. See Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," 65–66.
[66] Trudeau quoted in Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," 65.

more beneficial than exercise. This consensus started to form when physicians and researchers at the Trudeau sanatorium began publishing studies purporting to show that rest was better than exercise at building up a patient's resistance. For example, in 1917, Dr. Kinghorn of Saranac performed a comparative study between the rest cure at Saranac and work therapy at the Brompton sanatorium in England. His results showed that "patients who undergo prolonged and intensive rest treatment do not tend to relapse."[67] Moreover, in 1916, Dr. Joseph Pratt, who was endorsed by Trudeau, delivered an article at the National Tuberculosis Association and claimed that "when the average period of rest treatment was increased from seven weeks to four months, the disease was arrested in a distinctly larger percentage of cases."[68]

The fact that these results came from physicians associated with Saranac had a significant impact on the rest of the United States, for Trudeau's sanatorium was repeatedly looked upon as the model institution for new and upcoming sanatoria in America. By 1919 several of the largest, most prominent sanatoria began increasing the length of time that patients were order to stay in bed. Moreover, an increasing number of sanatoria medical directors began to prescribe rest for even their asymptomatic patients. This shift in treatment protocol can be seen in a 1919 questionnaire that Pratt sent to several of the largest sanatoria across the country. When asked how long they would keep afebrile patients with a positive sputum sample in bed, the Glendale County

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[67] Kinghorn quoted in Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," 67.

[68] Pratt, "The Evolution of the Rest Treatment of Pulmonary Tuberculosis," 194. A further line of investigation about the rest cure in America would be to study the influence of Dr. Silas Weir Mitchell, an American physician who developed and prescribed the rest cure for hysteria in the nineteenth-century.

Sanatorium in Minnesota answered 6 weeks, the Westfield State Sanatorium replied with 8 weeks, and the Rutland State Sanatorium in Massachusetts said 16 weeks.[69]

By the 1920s, many sanatorium physicians were advising all of their incoming patients to begin a regime of "complete rest," which often meant rest in its most extreme form. For example, the physician who admitted Will Ross to the River Pines Sanatorium in Wisconsin greeted him with the following instructions, "I want you to lie as nearly motionless as you can manage. Don't even think if you can avoid it. Once you have gotten yourself thoroughly disciplined to rest the way I want you to, you will be well started on the road to a cure."[70] Rest did not mean taking a mid–afternoon nap, or even maintaining a reclined position twenty–four hours a day. Rather, rest in the sanatorium meant being horizontal, without so much as a thought, a sound, or a twitch.

In the Washington State Sanatorium, all entering patients were instructed on how to be as sedentary as possible. MacDonald, a patient of the Washington State Sanatorium in Firland (which she called "The Pines") writes, "when we entered The Pines the Charge Nurse instructed us never to pick up anything from the floor. If we dropped something we were to wait for a nurse...."[71] But simply lying in bed was not resting either, for resting was done with the mind as well as the body. Not only were patients discouraged from deep breathing, talking, or singing in order to avoid overtaxing the lungs and heart; they were also discouraged from becoming mentally fatigued. In many sanatoria, writing

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[69] Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," 68. The specific question that Pratt posed to the medical directors of these sanatoria was stated as follows: "How long would you keep in bed a patient with pulmonary tuberculosis who presents the following features on admission? No fever, pulse slightly accelerated or normal, no loss of strength, but a few pounds underweight, slight cough with positive sputum, dullness and rales at the top of one lung."

[70] Ross, 86.

[71] MacDonald, 122.

and reading were often restricted for the first couple weeks of every patient's stay. Patients were advised to do everything and anything in their power to keep their pulses as low as possible. Or as MacDonald described it, "the nearer a comatose state" tuberculosis patients could approximate, the better their chances of recovery.[72]

The more passive a patient was, the better, for the medical community believed that it was only through inactivity that the tuberculosis "bugs" would become dormant. The advice of researchers and physician like Koch, Osler, Kretzschmar and Pratt had reached many sanatoria across the United States, and many physicians readily accepted the theory that activity was in direct conflict with the goal of walling off the bacillus in the lungs. Not only did certain physicians believe that rest would build up resistance; they also thought that prolonged "bed rest...allowed for the rebuilding of muscle, the gaining of strength, and the healing of diseased lung tissue."[73]

In order to communicate the importance of rest to their patients, physicians at Saranac began to adopt a metaphor to describe the difference between their more compliant, sedentary patients and their noncompliant, restless patients.[74] Advising his patient, Isabel Smith, on how to rest, Dr. Francis Trudeau claimed that "all my patients are either cows or antelopes....Being an antelope's O.K. when you're well, but it's *bad* when you're sick....Even in bed people can be antelopes, jumping up to look out the window, wriggling around, talking and laughing too much."[75] Like cows, the compliant patients who rested were understood to be reserving their energy and saving it for the natural healing process. As Trudeau described it, "the ideal tubercular patient is like a

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[72] MacDonald, 84.
[73] Lerner, 25.
[74] McClintock, 36 and Smith, 32.
[75] Smith, 32, emphasis in original.

cow. You should be flat on your back in bed twenty–four hours a day, never getting up, never writing, never reading, never even thinking."[76] On the other hand, the active, antelope–like patient was thought to be in danger of never being cured, for it was believed that any activity which increased the heart rate would have the effect of "wash[ing] out more poisons from the tuberculosis sore."[77]

While many sanatoria across the country prescribed bed rest for the initial months of a patient's stay, the amount of activity that a patient was allowed to undertake in bed varied slightly from sanatorium to sanatorium. In Ross' sanatorium, for instance, there seemed to have been no restrictions on reading and writing while in bed.[78] But a more representative sanatorium regime is found in MacDonald's account.[79] According to MacDonald, the Washington State sanatorium put every entering patient on strict bed rest for at least one month, which meant that a patient was restricted from all activities, including reading and writing. While on strict bed rest, a patient's day would simply revolve around the sanatorium–wide schedule of sleeping time and meals, all of which were served in bed.[80] If a patient was considered to be improving medically (that is, if she had a consistently normal body temperature and showed signs of weight gain) at the end of one month, the patient would be granted "up time," which meant that the patient would be allowed to perform minimal activities, such as fifteen minutes of daily reading or writing, or taking care of one's personal hygiene. The allotted time and level of activity

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[76] Smith, 32.
[77] MacDonald, 128.
[78] Ross, 85. One possible reason why Ross's regime was not as strict as MacDonald's was that Ross was in the sanatorium sometime between 1910–1920, when prolonged bed rest was just becoming a popular therapeutic regime.
[79] By representative, I mean in regards to the other autobiographies that I am looking at in this study. All of the other autobiographers mention writing and reading restrictions.
[80] Depending on the sanatorium, the duration and frequency of rest period would vary. Typically rest periods were scheduled from two–three hours, two–three times a day.

would be increased as the patient improved, until eventually (usually after a minimum of three months) a patient would be given ambulation privileges.[81]

While prolonged bed rest continued to be a predominant part of the American sanatorium regime, most sanatoria still continued with the tradition of a prescribing an abundance of food and plenty of fresh air. By the twentieth–century, a diet of foods rich in protein was thought to help build a patient's resistance, providing the body with the needed strength to ward off the tuberculosis germ. As a physician explained it to Ross, "when you've got tuberculosis, and especially when you're running a temperature, it's tearing you down as fast as if you were digging ditches all day and maybe faster."[82] In other words, the bacillus was believed to be taking up very precious energy stores and it was only through large quantities of food that the energy could be restored. According to Elizabeth Mooney, who recounts her mother's experience in Saranac, the diet was based on the rule that the patient was eating for three—"once for yourself, once for the germs, and once to gain weight."[83] The kind of diet that was needed to accomplish such goals was one of "six glasses of milk daily, six raw eggs, cream soups, Hollandaise, [and] chocolate cake with icing." [84]

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[81] MacDonald, 142.
[82] Ross, 91–92.
[83] Elizabeth Mooney, *In the Shadow of the White Plague* (New York: Thomas Y. Crowell, Publishers, 1979), 41.
[84] Mooney, 42. Rothman concurs with Mooney's description, reporting that at the Trudeau sanatorium "patients received three full meals a day and a glass of milk every four hours." (Rothman, 204) It is interesting to note that while milk was being used as a staple of the tubercular diet, at the same time, the bacteriological camp was divided about the infectiousness of bovine tuberculosis. According to Seale and Pattison, Koch declared in 1901 that bovine tuberculosis was harmless to humans, which had the effect of greatly hampering the movement for the pasteurization of milk. Those that opposed Koch's simply did not have the power or authority to easily override the influence of his theory. Because of this, "the effective safety of milk was delayed until World War II, with the result that generations of children were...exposed to the risks of bovine tuberculosis." (Seale and Pattison, 48)

Along with complete rest and ample food, patients were instructed to get plenty of fresh air, for it was believed that direct exposure to air, especially cold, winter air, lowered the workload of the lungs which thus hastened the healing process.[85] Trudeau, for example, instructed his patients to remain in the open air eight to ten hours a day.[86] Fresh air was understood to be such an essential element to rehabilitation that in Saranac the architecture of the town took on a wholly unique appearance. For instance, McClintock describes his first impression of Saranac while driving his wife, Helene, there for treatment:

> We passed a few houses, houses such as are seen only in Saranac, houses with porches on every side, at every corner, porches tacked precariously on the sides, jutting out from second and third floor rooms....and on all of them were men and women lying in long reclining chairs....silent and unmoving, a few reading, but most just lying there silent and unmoving.[87]

Peculiar to Saranac's sanatorium system were cure cottages, small home–like buildings in which only a few patients would reside. And "visually, structurally speaking, the cure porch...is what ma[de] a cure cottage a cure cottage."[88] Thus patients who were not restricted solely to bed rest, would receive their fresh air treatment in the Dettweilerian cure chairs wrapped in heavy horse blankets, with gloves, hat and woolen socks during the winter months.[89] But as larger institutions were constructed and rest therapy became

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[85] Lerner, 25.
[86] Rothman203.
[87] McClintock, 23.
[88] Philip L. Gallos, *Cure Cottages of Saranac Lake: Architecture and History of a Pioneer Health Resort* (Historic Saranac Lake, Saranac Lake, 1985), 7. Gallos provides a thorough discussion of the evolution of the porch and the various kinds of porches which were built in Saranac for the purpose of fresh air treatment. Gallos confirms McClintock's description of "tacked" on porches, explaining that cure porches were often added on to preexisting homes, including second–story sleeping porches (Gallos, 9). For a more detailed discussion (including visual illustrations and photographs) about cure porches and their various designs, as well as the cure cottage system in Saranac, see Gallos, 5–17.
[89] Lerner, 25.

a more prevalent form of treatment, the "down–patients," or those who were confined to complete bed rest, would often receive their fresh air simply from open windows—a situation which often made for uncomfortable living quarters, with "ice–cold, fog–dampened sheets." [90]

For many patients, the order to rest, eat and take in fresh air was welcomed, at least initially. Many of the new arrivals were very sick and were often working and raising children up to the time of their admission. Prior to being admitted to the sanatorium, MacDonald writes of her persistent colds (six in one winter), sharp pains in her lungs, and a heavy feeling over her heart, while working full–time and raising two children by herself. She was so fatigued at one point that she writes, "I began getting up in the morning feeling dead tired after dressing...I would feel like going back to bed instead of straining at the leash to begin the day's activities."[91] Likewise, admitted with a fever of 103 degrees, Ross reports that for his first four or five days at the sanatorium, he "slept almost continuously."[92] Moreover for others, the order to rest was a validation of their failing state of health. "Rest!" Smith exclaimed after her initial diagnosis, "It felt so good to lie down that for a moment I was actually glad. No one would call me lazy now or laugh at the pain in my chest." The diagnosis of tuberculosis had the effect of making a patient's symptoms more real, not only for the patient herself, but also for the others around her.[93]

But once they were well–rested and recovered from symptoms of fatigue, the patients in this study found living in the sanatorium a difficult struggle. Once they

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[90] MacDonald, 59 and Seagrave, 161.
[91] MacDonald, 30.
[92] Ross, 84.
[93] Smith,17–18.

confronted the reality of having to live every day confined to bed despite the fact that they often felt well, these patients fought feelings of restlessness, isolation and confinement. As several social historians have pointed out, the reality of the American sanatorium experience cuts through any romantic depictions of tuberculosis and the life of those who fell victim to it. From the viewpoint of ordinary sufferers, tuberculosis was an unwanted disease that had the potential of permanently disrupting the lives they led as healthy persons. Leaving behind the things that gave meaning to their lives—their jobs, homes, friends and families—patients in the sanatorium led a wholly new life of docility, confined by a new set of house rules which were not of their own making.

CHAPTER 2
"AN ISLAND OF ACTIVITY": SANATORIUM SPACE

Most recent histories of tuberculosis treatment in the twentieth–century do not portray the sanatorium movement in a very positive light. Skeptical that sanatorium treatment played any role in the decline of tuberculosis in Great Britain during the first few decades of the twentieth–century, Bryder describes the sanatoria as "total institution[s], sharing features with other institutions such as prisons, schools, lunatic asylums, and hospitals," where patients were treated like "children, incapable of making decisions for themselves."[94] In a similar vein, Rothman argues the typical American sanatorium was essentially an "incarcerative institution," "a waiting room for death," a place where "profound unhappiness, disappointment, and despair were the dominant emotions."[95]

Both Bryder and Rothman discuss sanatorium space in terms of confinement, claiming that patients were not only geographically cut–off from society but also socially isolated and controlled.[96] Sanatorium patients, according to these accounts, had to endure multiple layers of confinement from social stigmatization to domineering medical personnel who strictly enforced rules which regulated almost every minute of a patient's life. In the end, both authors conclude that often the sanatoria treatment regime ended up resembling behavior control more than therapy. But, interestingly, neither Bryder nor Rothman address the most extreme form of restriction: confinement to a bed.

The fact that prolonged bed rest was a common therapy to most American sanatoria is crucial, for it exerted the greatest influence on the patients' day–to–day

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[94] Bryder, 200, 205.
[95] Rothman, 226–227.
[96] Bryder, 200–201 and Rothman, 227–234.

experiences. To be sure, patients write about the same layers of confinement that several historians have discussed (i.e. the building, the staff, the rules). Yet their autobiographies predominantly revolve around their beds, for the hospital bed was not only a place where they spend most of their days, but it also played a crucial role in determining their states of mind. While some patients might have physically benefited from rest, the mental cost of such a treatment was great. Because of prolonged bed rest, many patients suffered from extreme degrees of anxiety and helplessness. In addition, prolonged rest had the effect of altering the patients' subjective notions of space to such an extent that they became more dependent on their beds; many of them became quite fearful of traveling relatively short distances. Moreover, patients on such a radical regime of prolonged bed rest could no longer relate to the world that stood outside the sanatorium walls. Because of their passive lot in life, they could not help but to be self–absorbed, which, in turn, left them with a deep sense of solitude and isolation.

The Confines of the Sanatorium

Because of the supposed therapeutic benefits of fresh air, many of the early American sanatoria were built in desolate areas, away from urban centers. The chosen sites for sanatoria were frequently small farming communities, such as Saranac and Rutland, Massachusetts.[97] Often, the name of a sanatorium reflected its physical surroundings, especially if it was in a desirous location, guaranteeing pristine air. For example, the Firland Sanatorium, where MacDonald was admitted, was named after the forest of fir trees which ensconced the attractive Elizabethan, Tudor–style building where the bed rest patients would reside.[98] Similarly, Ross took his cure at the River Pines

[97] Rothman, 217–8.
[98] Lerner, 23–25.

Sanatorium in Stevens Point, Wisconsin, a thickly wooded area 150 miles north of Milwaukee. Because of the remoteness, a move to a sanatorium usually required that a patient undergo a significant amount of travel either by car or train, making the transition from home to sanatorium a significant, if not also a frightening event. Once they were in the sanatorium, patients were geographically cut–off from the rest of society.[99]

Inside the sanatorium walls, patients did not necessarily experience the serenity and peacefulness that the surrounding environs promised. Rather, once inside, patients often encountered a wholly foreign and unwelcoming environment. Recounting her first impressions of the Firland sanatorium while sitting in a creaky wooden wheelchair, MacDonald describes being transported down a "long, draughty, pale green hall, each side of which was partitioned off into rooms." As she peered in each room she saw "white–covered single beds... and in each bed a head was raised," staring back at her.[100] She describes the ward to which she was assigned as spartan, "and square...[with] four casement windows, curtainless and blindless and opened wide. In each corner of the room was a bed, a bedside stand and a chair."[101] As MacDonald puts it, she was "deposited" in the bed in the southeast corner of the room, which was flush to the easterly–facing windows.[102]

Not only were patients physically confined to a building, they were also restricted to a set of social rules and regulations which controlled virtually every aspect of their daily lives. For instance, within the first couple hours of their arrival, most patients were forced to sign a rule book, demonstrating their willingness to conform to a seemingly

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[99] Bates, 69.
[100] MacDonald, 53.
[101] MacDonald, 55.
[102] MacDonald,73.

endless list of sanatorium do's and don'ts. McClintock describes receiving his very own rule book which had his number on it—8027:

> The book was full of rules, lots of rules. Everyone must be out of doors...between nine and twelve thirty and between two and five....No one could leave the grounds and go to town....The rules seemed endless.[103]

In accordance with McClintock's account, Seagrave estimates that there must have been as many as one thousand rules listed in her book.[104] Most of the sanatorium rules were instituted to prevent the spread of the contagion. For instance, the most important rules were "not sneezing in each other's faces, holding a piece of gauze before the mouth when coughing," and expectorating only into a sputum cup.[105] Other rules, though, were instituted to maintain order within the sanatorium walls. For instance, contact between the sexes was strictly prohibited not only because pregnancy was believed to be detrimental to the female tubercular's health, but also because such socialization was seen as a potential disruption to the sanatorium regime.[106]

In the hopes that they could control the spread of disease, sanatorium officials also restricted family visitation. According to the rule book at the Firland sanatorium, MacDonald was only allowed to see her children once a month for ten minutes and the other members of her immediate family twice a week for two hours.[107] But even when family members would come to visit, it was marked by a great degree of awkwardness and sadness, resulting from the ubiquitous fear of spreading the contagion to a loved one. Upon the first visit of MacDonald's two daughters, the one daughter, with tears in her eyes, exclaimed to her mother, "I would like to kiss you....[but] the nurse said that we

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[103] McClintock, 145.
[104] Seagrave, 50.
[105] Seagrave, 50.
[106] Rothman, 236.
[107] MacDonald, 51.

couldn't even touch your bed."[108] Likewise, McClintock recounts bringing his young son (Marco) into the sanatorium to see his tuberculosis–stricken mother as a heart–wrenching experience: "Helene did not touch him [Marco], did not kiss him. She was afraid she might cough."[109] Even intimate physical contact between husband and wife was discouraged—according to their rule book, the McClintocks, for example, were only allowed to kiss through gauze.

In addition to confinement to institutional walls and regulations, many sanatorium patients lived in cramped quarters. Seagrave, in a Midwestern state sanatorium, describes undergoing the open–air treatment in which there were "seven beds on...the side porch." In order to give the reader a better sense of how much room there was, Seagrave adds, "if I had seven arms I could punch everyone at once."[110] Likewise, MacDonald lived out most of her sanatorium stay in a room with three other women. In fact, in the Firland Sanatorium, a patient was in the company of several other patients even during her bathing time.[111]

While certain sanatoria dimensions might have been very restrictive, the order to remain in bed was by far the most confining part of the treatment regime. Not only was it limiting in a physical sense, but it also created a context which fostered mental

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[108] MacDonald, 143.
[109] McClintock, 112.
[110] Seagrave, 48.
[111] It should be noted that the living space that patients enjoyed varied slightly according to each particular institutions. The physical layout and construction of sanatoria across the United States often varied according to whether it was a state–run or private institution. For instance, when it opened in 1914, the Washington State Firland Sanatorium contained beds for 150 adults and 25 children. See Lerner, 24. In comparison to the private Saranac cottages which housed only 3–4 people, Firland was a rather large institution. As a result, patients of the state–run sanatoria often write of living in close quarters. But nonetheless, patients in private sanatoria often stayed in rooms by themselves, leading them to feel a great deal of loneliness, for they lamented the fact that they only had contact with nurses and doctors. See, for instance, Ross 85, 107.

boundaries. From the perspective of those patients who underwent the treatment of prolonged rest, the bed was the most immediate barrier which precluded them from taking on a more healthy mindset of feeling connected to their loved ones and the outside world and enjoying certain pleasures of individual freedom.

The Life of the Horizontals

For sanatorium patients, the hospital bed was the place where one would spend hours on end "taking the cure." In essence, it became the border of one's own personal space. Some patients likened it to a place of residence. As Ross writes, "my bed was my castle and I was cautioned to stay in it."[112] Not only were patients confined to a particular building, in a desolate area away from their families and society as a whole, but they were ultimately confined to the smaller area of a singular bed. Depending on the treating physician and the rules of the particular sanatorium, the degree of movement and the activities allowed within the confines of one's bed varied, but not to a great degree. Referring to his bed as an "island of activity," Ross suggests that the protocol to rest was not as strictly enforced as it was in other sanatoria.[113] However, for some patients who endured strictly–enforced rules of complete passivity, the bed became more of a foe than a friend. Smith describes her bed as an obstruction of her will to move with the "blankets tucked in all the way up on both sides, forming a tight envelope in which [one] was held like a vise."[114] Taking the little liberty that she had, Smith writes, "I turned my head from side to side, rebelling at the feeling of confinement."[115]

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[112] Ross, 85.
[113] Ross, 100.
[114] Smith, 29.
[115] Smith, 29.

Lying in a recumbent position on a daily basis, sanatorium patients naturally had a very limited and peculiar perspective of their physical surroundings. Describing the daily life of someone who spends the entire day in bed, the sanatorium autobiographies often focus on mundane objects that only a person who is in a horizontal position would hold in his of her field of vision. For instance, a common object of description is the ceiling. Apparently feeling the need to explain his frequent excursive musings, Ross writes, "when you are lying on your back, the easiest place to look is up."[116] He continues, "I lay for a long while staring up at the ceiling. There wasn't much on the ceiling to look at but a neat row of boards painted a neutral gray....That curious little break on the board overhead must have been where the carpenter's plane had slipped."[117] At times the ceiling claimed so much mental concentration that some patients became incensed with their obsession with such mundane things. Indeed, patients like Smith understandably became resentful of her monotonous surroundings, "[my] room...looked lonely and bare...[with] many of the familiar objects which had made my former dwelling into a home...stowed out of sight. I...lay [in bed], staring at the ceiling, hating each and every crack."[118]

The day–in, day–out scenery of the same four walls and the same ceiling became so monotonous that even the slightest change seemed monumental. MacDonald provides her readers with repeated and very detailed description of her view out the window from the second floor where she "could just see the tip of one of the poplar [trees]....[and] the sky was a dirty white...."[119] One day when she was looking at this

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[116] Ross, 87.
[117] Ross, 87.
[118] Smith, 70.
[119] MacDonald, 73.

typical scene out of her window, MacDonald writes, "while I watch [the poplar tree], one small leaf let go and dropped limply through the misty air. Compared to the hospital it seemed like an act of hysterical activity."[120]

Living life in a horizontal position was not only a drudgery, but it also had disturbing effects on the patients' mental well–being. First, assuming such a position compounded their feelings of helplessness and dependency.[121] "Everything [about the sanatorium]," Smith writes, "seemed designed to lull me into a state of passive and disinterested acquiescence...."[122] She further explains that it was the bed rest regime in particular that made taking on an active role in her care virtually impossible: "plump pillows, soft blankets and the deep comfort of an innerspring mattress mean snuggle, not struggle. They undermined, rather than strengthened my will to participate...."[123] While the general consensus at this time was that patients should be compliant, passive recipients of a physician's medical decisions, living horizontally only helped to reinforce the patients' non–participatory role in their own health care.[124] Confined to bed, sanatorium patients assumed a submissive position. And because they were told that any

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[120] MacDonald, 75.

[121] It is interesting to note that although there is evidence that a significant number of patients discharged themselves against medical advice, none of the autobiographers in this study seem to have contemplated such a course of action themselves. The description of "living horizontally" is influenced by Thomas Mann, *The Magic Mountain*, trans. John E. Woods (New York: Vintage International, 1995). Throughout the novel, the leitmotif of "living horizontally" takes on several different layers of meaning. The character of Settembrini is the one who facetiously coins the phrase "horizontals," mocking the unequivocal conformity of those who take the rest–cure, willingly obeying sanatorium rules. In his eyes, assuming a horizontal position ultimately meant taking on a certain kind of submissive role. See Mann, 71.

[122] Smith, 58.

[123] Smith, 58.

[124] With the rise of laboratory medicine and new esoteric knowledge that only doctors could access, patients went from active participants in medical decision–making during the better part of the nineteenth–century to passive recipients of care by the twentieth–century. In fact patients, such as Seagrave, were repeatedly told not to "rely too much on [their] own judgment." (Seagrave, 37) For more on the shift in doctor–patient relationship from the nineteenth– to twentieth–century, see Rothman 179–197.

physical movement or usage of the lungs was harmful to their health, most patients remained motionless and silent; in effect, they were dissuaded (whether directly or indirectly) from asserting themselves. Indeed, the autobiographers of the sanatorium experience concur that being confined to a bed and restricted from virtually all activity led them to adopt an unwanted, passive stance toward the world—one in which each patient had to struggle to maintain his or her will to live.

Besides it symbolizing a position of submission, living horizontally also served as a reminder of the possibility of one's own demise.[125] Although death was often a taboo subject in the sanatorium, several of the autobiographers still admit that they would often experience a kind of existential angst, despite the fact that, for much of the sanatorium stay, they had a general sense of physical well–being. But lying in bed 24–hours a day and being told that they were sick with a grave disease eventually took its toll. The dark foreboding feelings about death and dying surfaced and were most pronounced when the patients were on strict bed rest.[126] Ross reveals one moment of extreme fear that occurred during one of his rest periods on a cure porch. He writes, "On my narrow porch

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[125] This idea is influenced by Mann. Towards the middle of *The Magic Mountain,* Mann gives the metaphor of "living horizontally" an additional meaning of death. Describing death as the permanent "horizontal form of existence," one gets the sense that, in a jocular way, Mann sees sanatorium life as a rehearsal, where patients are practicing their supine positions of rest, getting it just right for opening night, or, better yet, for the final day of judgment. While Mann uses the metaphor of living horizontally as a literary device, his analysis also contains insight that captures an important facet of sanatorium life. See Mann, 270–300. Literary critic, James Wood, has also discussed the importance of Mann's "horizontal" leitmotif in regards to death. See James Wood *The Broken Estate: Essays on Literature and Belief* (New York: Random House, 1999), 112–113.

[126] I base this conclusion on the fact that the autobiographers in this study only wrote about their fear of death when they were on bed rest and not later in their rehabilitation when they were given ambulatory privileges and allowed to participate in occupational therapy. One obvious explanation for this would be that death was not as much of a threat when patients were given activity privileges, for in receiving these privileges, they were considered to be medically progressing towards health. Another plausible explanation, which is tied to the theme of teleology in chapter 3, is that with activity, patients were given a goal which occupied their thoughts and distracted them from the possibility of death.

I felt close to the earth, closer than I wanted to be. It made me afraid, it made me think of death."[127] MacDonald describes a similar feeling of fear of death when lying in bed at night. Not being able to sleep at night because of too many rest hours during the day, MacDonald writes "[I] had long sleepless hours to think, to listen, and to observe, I...began to see [death's] evil peering face, to hear him shuffling up and down the corridors in the night."[128] Perhaps for MacDonald and Ross lying horizontally simulated too closely the final position of death, evoking fears that they were heading for a final resting place rather than the return to the lives they had left behind.

Aside from the mundaneness and anxieties of death which seemed to accompany the horizontal life, the sanatorium patients also indicate that continuous confinement to a bed eventually led them to experience space differently from when they were healthy. Smith sums up the phenomenon of her changed perception of space best when she writes, "the longer I was sick, the longer I lay in bed, the more the molehills began to appear as mountains."[129] The thought of performing normal, everyday tasks, began to seem like daunting undertakings. This became particularly apparent to patients once they were taken off strict bed rest (usually after three months) and given ambulatory privileges.[130] The newly gained independence of being able to walk was received with much awe and speculation. For instance, when Ross was allowed to eat his meals in the dining room, he treated his new independence as if it were a very special occasion. Using the metaphor of

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[127] Ross, 95.
[128] MacDonald, 160.
[129] Smith, 61.
[130] MacDonald explains the rehabilitation timetable at her sanatorium, claiming that if patients showed signs of physical recuperation after one month, they would be granted bathroom privileges, and would be allowed 15 minutes of writing and reading. After 2 months, reading time would be increased to 30 minutes. After 3 months, recuperating patients would be granted ambulation privilege, which meant that they could walk to different areas within the confines of the sanatorium. MacDonald, 142.

taking a voyage by ship, Ross describes his new freedom in terms of traveling great distances when he writes, "I was delighted to be getting away from my mattress island and launching off towards to the mainland [of the dining room]."[131] From the perspective of a "horizontal," who spent three to fours months on strict bed rest, a simple everyday task like walking to the dining room became an exciting voyage, which required much planning and brought about anticipation and anxiety. What would be a small, almost insignificant, distance to a healthy person expanded exponentially for bedridden sanatorium patients.

A transformation in the perception of space, such as Ross', suggests that while it is true that sanatorium patients were confined to a particular institution—to its rules, and to a bed—such a description only explains how objectified, physical space had constricted. But, when one looks beyond the *objective* facts of confinement to investigate how this affected the patient's *subjective* awareness of space, one finds that for patients like Smith and Ross, space often seemed to expand. They both felt as if the distance between themselves (and their beds) and anything beyond their beds had increased. Confined to a bed, to an objectively confined space, sanatorium patients naturally focused on their immediate surroundings of the ceiling, the window, the bed, or the room. In fact, during the initial months of a sanatorium stay, it was often the case that patients did not even know what lay outside of their own doors.[132]

Thus, the living space of a single room and perhaps the porch on which they were taking the rest cure became the dominant context of the patients' lives. Sanatorium confinement to a bed relegated them to a context in which space took on a new meaning–

[131] Ross, 113.
[132] Ross, 85.

–where molehills looked like mountains, and a trip to the dining room looked like a voyage to a far–off, distant land. At times, such a change in the daily life of a horizontal was accepted with great enthusiasm. But more often than not, such a change in perceptual awareness was met with fear. For example, even though Ross was at first enthusiastic about his ambulatory privileges, he latter writes of feeling of a greater dependency, for he did not want to leave his bed. As he writes, "I was afraid to face the outside world."[133] Living life confined to a bed, the outside world must have truly seemed like a great expanse.

In the Kingdom of the Sick

While prolonged bed rest often contributed to feelings of helplessness, heightened fear of death, and altered perceptions of space, the most pronounced psychological effect of confinement was that patients often felt a profound social isolation from the outside world and their loved ones.[134] The geographical separateness and confinement of the sanatorium eventually led many patients to feel experientially disconnected, sometimes to the point of being unable to relate to the people or the events in the outside world. That certain types of sickness promote one to feel alienated from healthy people is a phenomenon that many scholars have discussed. But as J. H. van den Berg points out, a patient's alienation is most acute when he or she is confined to a bed, for the once

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[133] Ross, 122.

[134] I chose to entitle this section "Kingdom of the Sick," for all of the autobiographies make as distinction similar to Susan Sontag's metaphorical kingdoms of the well and sick. See Susan Sontag, *Illness as Metaphor and Aids and its Metaphors* (New York: Anchor Books, 1990), 3ff. In the sanatorium narratives, patients write of a world "inside" the sanatorium walls which is very different from the "outside world." See, for example, Smith, 43 and Ross, 116, 122.

inhabited world of the bedridden patient only "echoes as though from an inaccessible distance."[135]

Indeed, the more time sanatorium patients stayed in bed, the greater their sense of alienation became. For example, MacDonald explains that as her time in bed increased, so too did her apathy toward her family and friends.

> At first when visitors told me of happenings in the outside world I was vitally interested and relived each incident vividly with the telling. Then gradually, insidiously, like night mist rising from the swamps, my invalidism obscured the real world from me and when my family told me tales of happenings at home, I found them interesting but without strength, like talk about people long dead.[136]

To MacDonald, the people who made up the outside world had become remote and thus they inhabited only a place in her distant memories. Not being able to physically associate with her family and friends in the context of her home or community, MacDonald lacked the necessary experiential interactions which allow one to take an interest in others and appreciate the meaning of those experiences. Moreover, because of her confinement to bed and resultant sense of "invalidism," the outside world no longer seemed "real." Relating to her family's stories became difficult for MacDonald because to her "the only real things were connected to the sanatorium. The only real people [were] the other patients, the doctors, the nurses."[137] Under the sanatorium regime, a mental wall was constructed, creating a clear divide between the healthy and the sick. From her bed, MacDonald could no longer reach those for whom she cared, nor could they reach her; confinement had undermined her ability to connect with her family and

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[135] J. H. van den Berg, *The Psychology of the Sickbed* (Pittsburgh: Duquesne University Press, 1966), 26, quoted in Drew Leder, *The Absent Body* (Chicago: The University of Chicago Press, 1990), 81.
[136] MacDonald, 164–5.
[137] MacDonald, 165.

friends to such an extent that she had to struggle against a feeling of indifference towards her pre–sanatorium life.

Other patients, like Smith, not only began to lose interest in their families, but also in society as a whole. On the eve of World War II, Smith writes about the difficulty of relating to the political happenings of the outside world; "[the radio] spoke of a world remote and far away. Only my bed, table, bureau, and two chairs seemed real. I had little tangible proof that anything else existed."[138] While both Smith and MacDonald intellectually knew that the world outside of the sanatorium was real and that their families, friends and society still existed, being confined to the sanatorium nevertheless had the effect of making everything beyond the sanatorium walls so distant that it no longer appeared to be physically or mentally concrete, making worldly events seem unimportant.

One of the major contributing factors to this felt alienation on the part of the patients was that many of them started to forget what made their former ways of life meaningful. Thinking about her life experiences before she was admitted to the sanatorium, Smith began to ponder the significance of some of the fundamental premises under which the outside world operated.

> I could remember distinctly...the appearance of a street, but I had forgotten the way a sidewalk felt beneath my feet. I could remember the business of a morning at home, but what had been the tasks which made those hours so full? I stared sometimes in bewilderment at the automobiles hurrying back and forth on the highway below my porch and tried to visualize the press of business and the rush of everyday affairs that kept these people forever on the go—but I had little success.[139]

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[138] Smith, 168.
[139] Smith, 104.

It is not surprising that Smith suffered a kind of kinesthetic forgetfulness. After all, she spent months confined to a bed, restricted entirely from ambulatory privileges. But her forgetfulness did not simply stop with proprioceptive feelings. Rather, from her completely passive state in bed, Smith could not remember the motives behind the dynamism of the outside world. Although she was once part of the outside world as a student nurse, Smith could no longer understand the *raison d'etre* of the healthy, working people whom she viewed from her sanatorium window.

As memories faded and the everyday happenings of the outside world started to look foreign in comparison to the sanatorium, some patients found it difficult even to communicate with their friends and families. For example, Smith writes, "I wanted desperately to speak the same language as my friends...[but] we did not, for the most part, even think the same thoughts."[140] The problem for Smith was that while her friends and family concerned themselves with the business of the everyday world, she was primarily absorbed with the events of the sanatorium. So whereas a healthy family member might be concerned with a job promotion or raising a family, sanatorium patients were preoccupied with body temperatures, weight gain and rest. Even when family members and patients used a common vocabulary and ostensibly engaged in a discussion in which both parties understood what the other was saying, the patients still felt as if their families didn't understand. As MacDonald writes, "I was certain that my family hadn't the least idea of the meaning of the words rest and quiet...."[141] So although family members may

[140] Smith, 146.
[141] MacDonald, 232.

have uttered the right words, patients like MacDonald felt that their loved ones did not understand the full import of the meanings of words such as rest.[142]

Although the feeling of alienation was at times all–pervasive for the patients, most of them did not treat it as an unavoidable fate. The autobiographers in this study not only indicate that they were self–consciously aware of their felt isolation; but they understood such feelings of alienation to be undesirable and thus looked for the cause of such emotions, the removal of which would enable them to attain a healthier state of mind. Most of them attributed the cause of their isolation to themselves—they felt that they had allowed themselves to become so self absorbed by their own state of sickness that they could not think of anyone else. Even a single mother like MacDonald had this experience. Although she constantly worried about how she could support her two children, MacDonald nevertheless was conscious of the fact that her interests in others and the outside world were dwindling. She blamed her lack of interest in part on "the childish self–centered attitude of an invalid. What I was doing, how I felt, what was to happen to me became more and more important to me as time went on."[143] MacDonald felt that the concern for her own welfare had absorbed the scope of her attention to such a degree that she could no longer give adequate attention to those closest to her.[144] And, in her mind, she had only herself to blame for allowing such feelings of egocentrism to dominate her life; MacDonald firmly believed that her egocentrism was a flaw in her character that she could willfully overcome.

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[142] In fact, it is likely that this type of communication gap persisted well beyond a patient's discharge from the sanatorium, for as Bryder demonstrates, many patients continued a modified sanatorium life at home even after they were discharged. See Bryder, 215ff.
[143] MacDonald, 164.
[144] Mary C. Rawlinson, "Medicine's Discourse and the Practice of Medicine," in *The Humanity of the Ill: Phenomenological Perspectives*, ed. Victor Kestenbaum (Knoxville: The University of Tennessee Press, 1982), 74– 77.

While some patients blamed themselves for their self–centered attitude, others, like Smith, recognize that the real culprit was the rest cure and confinement to bed. Smith seemed to fully appreciate the detrimental effects that confinement had on her psyche. As she writes, "I longed to lose myself in something so big that my own [egocentric] concerns would become unimportant. But where and how was I to find it in a twelve by twelve room?"[145] Because of her situation in the sanatorium, Smith found it virtually impossible to think of anything else but herself. At one point she candidly admits that the rest treatment was making her much worse, rather than better. From her bed she writes, "I was stagnating in the swamp of my woes. The only thing that flourished, and that most unhealthily, was my ego."[146] Someone like Smith indicates that tuberculosis itself was not the only causative factor in feelings of solitude. Rather, it was the treatment that was the main cause—lying in bed for weeks and months promoted egocentrism and isolation that was almost impossible to overcome.

[145] Smith, 168.
[146] Smith, 56.

CHAPTER 3
THE POSSIBILITIES OF PROJECTION: SANATORIUM HORIZONS

In his book entitled *The Absent Body*, Drew Leder argues that because sickness brings about physical pain and discomfort, an ill person's concern for his or her own body eclipses future plans and goals. In making this argument, Leder claims that when sickness ensues, a person is no longer able to project goals onto the future. That is, the normally projecting self is disrupted insofar as the "rays of intentionality [which normally] radiate outward" from a healthy person collapse during times of sickness. At these times the body is no longer seen as a reliable vehicle through which one's future plans can be accomplished.[147] Because future possibilities and life plans seem to be no longer feasible, those who suffer from sickness, Leder argues, experience a "teleological constriction."[148]

In light of the tuberculosis narratives, Leder's theory of teleological constriction characterizes one important facet of the sanatorium experience. Indeed, the times in which the autobiographers actually felt sick and suffered from physical symptoms of tuberculosis, they write that their bodies were failing them and that their future plans were outstripped by their feelings of sickness. Yet, because the autobiographers had incipient cases of tuberculosis, many were asymptomatic for most of their sanatorium treatment. Given this fact, it would seem to follow that because they did not experience any bodily symptoms of their disease, they would not suffer from a teleological constriction.

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[147] Leder, 80–81. Many of the ideas for this chapter were inspired also by the phenomenological analysis found in Martin Heidegger, *Being and Time*, trans. John Macquarrie and Edward Robinson (New York: HarperCollins, 1962), 185ff., 97–109; and Maurice Merleau–Ponty, *Phenomenology of Perception*, trans. Colin Smith (New York: Routledge, 1996), 101ff.
[148] Leder, 79–83.

But this was not the case. For although most sanatorium patients were not burdened by symptoms which constantly put their future plans into doubt, they did have to endure a treatment regime which, in essence, forced a kind of teleological constriction upon them.

In the sanatorium narratives, there is a subtle yet crucial distinction to be made between, on the one hand, a teleological constriction which may arise from patients focusing on their physical ailments to such an extent that they can no longer even *conceive* of future possibilities and, on the other, a constriction which occurs as the result of external restraints (such as prolonged bed rest and restraining medical advice) which preclude patients from *acting* toward goals they continued to hold. That is, although many of the patients were asymptomatic and thus were able to still imagine and dream of their futures, they nevertheless began to experience a kind of teleological constriction that resulted from not being able to act toward their own plans since they were expected to remain in bed for an extended period of time despite their subjective feelings. Thus, for many of the patients in the sanatorium, the disruption of making life plans did not simply arise as a result of the disease in itself. Rather the order of prolonged bed rest and other medical restrictions on their lives had the effect of collapsing their sphere of future life plans so that the only meaningful purpose left was to "take the cure."

The Patient's Worldview

Since sanatoria in the second and third decades of the twentieth–century began favoring admissions of incipient cases of tuberculosis, many patients who were admitted during this time period had a general sense of physical well–being for a large majority of their sanatorium stay. Nevertheless, they still had chronic illnesses and were thus prone

to occasional relapses that were marked by a wide–array of symptoms such as pleurisy, increased body temperature, and lethargy. Often, the physical manifestations of their disease brought about feelings of despair and grief. Symptoms of pain and discomfort served as reminders of their fragile states—recuperation was by no means fully guaranteed. Recounting a relapse of his own, Ross writes, "my temperature persisted....my horizons were again limited to my mattress."[149] Invoking the metaphor of "limited horizons," Ross is expressing feelings of teleological constriction. And, it was the kind of constriction that, in accordance with Leder's theory, was largely due to the experience of bodily pain or suffering. Because his body was ostensibly failing him, any thoughts that began with the conditional of "when I get out of the sanatorium" were suddenly put into question, replaced, perhaps, by an image of a "slamming coffin lid."[150] He had difficulty imagining any future plans, for his feelings of sickness forced him to narrow his outlook and focus on the primary and necessary goal of overcoming his febrile state.

Along with naturally occurring relapses, many sanatorium patients during the twentieth–century suffered iatrogenic pain from extreme and often hazardous surgical methods which were often employed as experimental means to combat the disease. In the absence of effective drug therapies to combat the tubercle bacillus, procedures such as artificial pneumothorax (the injection of gases into the lung cavity) and thoracoplasty (the resection and removal of part of the rib cage) were very popular in the sanatoria of the early to mid– twentieth–century.[151] Both procedures were used to induce the affected lung to collapse, a technique that was believed to hasten recovery. Although revered,

[149] Ross, 119.
[150] MacDonald, 189.
[151] Seale and Pattison, 48–49.

these procedures were often quite painful. After undergoing her first pneumothorax, Smith writes, "I lay bolstered high on my pillows...with every breath making me wince, I knew that all my hopes for the future had collapsed along with my faithless lung."[152] While in pain, Smith indicates an acute bodily awareness that essentially made her future uncertain. As her hopes collapsed, so too did her teleological sphere. Like Ross in his relapsed state, Smith's goal of becoming pain–free overshadowed any of her other future goals.

But outside of the times that they were recovering from surgery or recuperating from a relapse, the autobiographers in this study indicate they were often symptom–free. In fact, many patients shared the same sentiment as Smith, who claimed that after a week or so of bed rest, she "felt well and more rested than [she] had in years."[153] Similarly, after the first two weeks of the rest cure, MacDonald writes:

> My sense of well–being was so great it was almost choking me....The depression and terrible sense of foreboding I had been wearing around my shoulders since the night I learned I had tuberculosis, had been lifted....I felt well![154]

Considering the fact that prior to their admissions, many sanatorium patients were working full–time jobs and taking care of a families while combating symptoms of coughing, pleurisy, and low–grade fevers, it is not at all surprising that, in comparison to their pre–sanatorium life, many of the patients felt healthier after a couple weeks of the rest cure.

For most of their sanatorium stay, many patients felt perfectly capable of carrying out simple daily activities, for they had a teleological drive similar to that of a healthy person. Making future plans and goals seemed perfectly normal and appropriate, for

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[152] Smith, 50–51.
[153] Smith, 46–47.
[154] MacDonald, 107.

having a sense of physical well–being, their bodies were not indicating that they should think otherwise. Patients like Smith and Seagrave, who both had fiancés upon their diagnosis of tuberculosis, continued with wedding plans during the initial months of their sanatorium stay. As Smith recounts, "Ted [her fiancé] and I planned endlessly for the future...."[155] Likewise, Seagrave, who maintained a correspondence with her fiancé, Darwin, wrote him a letter saying "there can be no comparison between this [sanatorium living] and entering upon my life with you this fall, as [we] are planning. There should be no question of the feasibility of these plans...."[156]

If wedding plans were not in the making, other goals like returning to their careers, homes and families occupied the patients' minds. McClintock recounts how when his wife Helene recuperated from her pleurisy pains, she said, "I'm beginning to want so many things....I lie here all day and think about having a house and good furniture and...a car...."[157] MacDonald also continued to have thoughts about returning home, but her concerns mainly revolved around her two children. Well–rested and feeling healthy, she writes, "I spent the rest hours making plans for the future....I was able to think of home and the children without the slamming of a coffin lid."[158] Still other patients had plans to return to their professional careers once they had fully recuperated. Smith claims that, during the initial month of her sanatorium stay, she "never ceased to ask: When can I finish training?" For despite her setback of tuberculosis, she fully intended to continue pursuing her career as a nurse.

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[155] Smith, 52.
[156] Seagrave, 171.
[157] McClintock, 128.
[158] MacDonald, 109.

While for many patients the ability to plan for the future still thrived, what ultimately mattered in the sanatorium was medical fact—facts that did not necessarily coincide with subjective feelings. In the early decades of the twentieth–century, with the increased influence and acceptance of germ theory and laboratory medicine, the incongruity between *feeling* well (subjective perception), and *being* sick (empirical fact) was something to which many of the sanatorium patients had to become accustomed. In her recent book *Typhoid Mary*, Judith Leavitt claims that during the turn of the twentieth–century, there was a rift between the "official" or professional worldview which understood sickness and disease in terms of germ theory and the patient worldview which relied more humoral notions of symptomatology. The worldview of laboratory–minded physicians and public health officials was one dominated by laboratory sciences and notions of "healthy carriers." But to the patients who had contagious diseases, like Mary Mallon, the notion of a "healthy carrier" was far from obvious, for they did share the same knowledge base as their treating physicians. Instead, as Leavitt points out, Mallon relied on "her *experience* as a healthy woman above a science that defined her as infected."[159] Without a microscope or access to the esoteric knowledge of the new laboratory sciences, many patients relied on what they knew best: how they physically felt.

In the sanatorium narratives of the early twentieth–century, there is a clear indication that patients had some difficulties accepting the new medical evidence that deemed them sick. Exhibiting a worldview similar to Mallon's, Smith writes, "I didn't know how sick one can actually be even though feeling better."[160] Smith explains that

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[159] Leavitt, 35, emphasis added.
[160] Smith, 24.

she had difficulty believing the seriousness of her disease because it was not made apparent to her. Her subjective feelings were that of being healthy—she had no other empirical evidence which indicated otherwise. Smith writes about the difficulty in coming to terms with the disparity between her subjective feelings and the empirical findings of the medical sciences:

> I was presumably patching a pair of damaged lungs. But I could not SEE my lungs. And the few glimpses I ever had...[of] my X–ray pictures revealed nothing I could understand....Without seeing, believing was difficult.[161]

Smith's emphasis on *seeing* actually highlights a fundamental change that took place within the medical field as it shifted from the pre–modern humoralism to the clinical and laboratory sciences of late nineteenth–century. Under the medical paradigm of humoralism, both patient and doctor would rely on outward symptoms for diagnosis and treatment, whereas the laboratory sciences increasingly based medical knowledge on microscopic findings.

Michel Foucault in his *The Birth of the Clinic* describes this shift in the history of medicine as a reorganization of the "medical gaze."[162] While humoral physicians relied mostly on outwardly exhibited symptoms, modern clinical and laboratory medicine adopted a new gaze which "was not content to observe what was self–evident...."[163] Instead, it was a gaze that penetrated beyond that which was immediately apparent. Through the use of microscopes and X–rays, physicians employed a new kind of perception that went beyond the individual patient. But what became visible to medicine remained largely invisible to the patient.

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[161] Smith, 55, emphasis in original.
[162] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage Books, 1994), 89 ff.
[163] Foucault, 89.

Although certain patients had some personal misgivings about the new laboratory sciences, they rarely, if ever, acted on their skeptical inclinations. Throughout the sanatorium autobiographies, one finds that, for the most part, patients readily complied with medical advice. Most patients thought of physicians as the "experts" concerning health and disease, for they possessed a high degree of skill and thus knew what was best for the welfare of the patient and community. On the other hand, patients were expected to assume the sick role. And if they wanted to get well, they had to cooperate with medical advice and be willing to refrain from normal activities and responsibilities. Ultimately, for this type of medical relationship to work, both parties had to understand that the patient was the passive recipient of care and was "unable to get better by his or her own decisions and will."[164]

But even though patients frequently acquiesced to the doctor's orders, the discrepancy between feeling well and being sick still took its toll on a more personal and psychological level. Because medical fact ultimately held more weight than subjective feelings in treatment protocol, patients were restricted to prolonged bed rest despite their feelings of well–being. As a result, patients not only had to contend with an unrelenting feeling of restlessness, but they were also forced to narrow their horizon of possibilities to the singular goal of being discharged from the sanatorium.

Restlessness

Often having to take it on blind faith that they were sick, sanatorium patients had a difficult time tolerating the passive existence of confinement and the rest cure, for they felt well and thus maintained a mind–set of planning and doing. Despite the good

[164] Much of this discussion is based on Talcott Parsons' theory about patient and doctor roles found in Seale and Pattison,111.

intentions of the medical community to keep tuberculosis patients completely passive and removed from the worries of everyday life, nothing could stop many of the patients from planning and thinking about future endeavors. "Even here, in this Adirondack village," Smith writes, "[my life] continued to have color and possibilities which did not produce the mental attitude prescribed for a resting patient."[165] In fact, Smith claims that having even simple daily goals was necessary for her will to live. She writes:

> Each morning I awakened with the same thought. I must find something, somehow, to which I could immediately look forward. This daily search was well worth the effort, for, once found the anticipated pleasure would serve to enliven my spirits and give zest and meaning to the hours ahead....and anticipation to me was life. [166]

Although in the early days of her sanatorium stay Smith believed that anticipation was enough to satisfy the prerequisites of living, she, along with many other patients, would later come to realize that simply dreaming of goals without being able to act towards them was not enough to satisfy the desires of a normally projecting self.

The sanatorium life of prolonged bed rest was a unique challenge to the patients' teleological drive, for although they could still mentally conceive of future plans, they were prohibited from acting towards any of those goals. As a result of such restriction, patients suffered a kind of teleological constriction which manifested itself in symptoms of persistent restlessness. After her initials days in the sanatorium observing her roommates, Seagrave writes, "Perhaps I'll feel more unruly when I feel better physically," knowing full well that the imposed rest cure would be difficult for her to carry out once her symptoms of fatigue and listlessness subsided. [167] Seagrave's portent was very insightful, for every autobiographer complained of restlessness only after he or

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[165] Smith, 39.
[166] Smith, 47.
[167] Seagrave, 56.

she began to feel well. "My...sense of well–being returned but...it was accompanied by a terrible restlessness and irritability," MacDonald writes after undergoing two weeks of the rest cure. She continues, "I felt perfectly well and it drove me insane to lie there hour after hour, day after day, doing nothing."[168] Restlessness was primarily a symptom of those who felt well because it was born out of a fundamental discontinuity of the normally projecting self—of having beautiful and exciting plans in the mind's eye but being inhibited from setting forth to accomplish them.

In some cases, confinement to bed only served to further intensify the patient's desire to conceive of future plans. Only a few weeks after her arrival to the sanatorium, Smith, in a state of frustration, contrasts her active mind with her passive body, "Lying still became a difficult task in which my mind refused to co–operate. My thoughts charged ahead with a speed that almost compelled action. Sleep eluded me as I endlessly planned for the future, not just tomorrow, but next week, next year...."[169] The tone here suggests that Smith was becoming compulsive about the future just by the very fact that her teleological desires were not being met. Simply thinking of the future was not enough for her; she wanted to act toward it.

For most patients, planning for the future was often extremely dissatisfying, primarily because it was futile, for they were under the strict medial advice not to do anything, even the most menial tasks. In fact, it was virtually impossible to contrive any goals that conformed to sanatorium rules. As Smith laments, "The inability to do anything for myself except dab my nose with Kleenex began to get on my nerves." She claims that she repeatedly asked the medical staff to allow her to do more for herself.

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[168] MacDonald, 113.
[169] Smith, 47.

She writes, " I begged to hold the washcloth in my own hands, to scrub my own teeth and comb my own hair."[170] Performing even the simple everyday tasks, life personal hygiene, was important to Smith, for she intuited that the teleological constriction that was being forced upon her through prolonged bed rest was detrimental to her psychological health.

Patients in the sanatorium were thus put in the difficult position of trying to come to terms with two opposing desires. One the one hand, many could not help but to dream of the future and, in fact, many believed that such a mind–set would benefit their mental well–being. But, on the other hand, such mental activity (they were told) was detrimental to their physical health, putting their chances for a cure in jeopardy.

The struggle, then, for the sanatorium patients who wanted to remain in good standing with their physicians was that as they progressively felt better, they had to *remind* themselves that (according to their sputum and X–rays) they were sick. This was a difficult undertaking, for as the physical symptoms of their disease wore off, not only did patients feel better, but they also experienced a kind of psychological solace since their disease state was less threatening. "As my fever subsided," Smith recounts, "the spot on my lung did not seem so menacing...."[171] But in order to continue to pursue their hopes of being cured, patients had to subvert their subjective feelings to scientific facts. Smith describes such a task as a daily battle when she writes, "I had to remind myself continually that my lungs were sick, because the remainder of my body actually seemed overcharged with energy."[172] MacDonald recounts a similar struggle and conveys what must have been a trying situation for medical professionals as well. "[The

[170] Smith, 23.
[171] Smith, 23.
[172] Smith, 46–47.

medical director] had had a most difficult time teaching me that I had tuberculosis," MacDonald explains, "he still wasn't sure that I realized how serious my illness had been."[173] This discussion between MacDonald and her medical director took place on many occasions throughout her four–month stay. In fact, even upon her date of discharge, MacDonald's doctor gave her the following words of advice: "the important thing...to remember is...that you had a cavity in your left lung and a shadow in your right lung. You have had a serious tuberculosis, do not forget it."[174] Even until the end, it still took a great deal of conscious effort on MacDonald's part to remember her microscopically fragile state.

Narrowing the Horizon

Despite the detrimental side–effects of prolonged bed rest, some patients persisted in making life plans. But, as soon as these patients shared their future plans with their treating physicians, most of their goals were deemed medically unsound. Trusting the advice of their physicians, most sanatorium patients eventually gave up their broad range of life–plans and replaced them with the solitary and "medically acceptable" goal of taking the cure in the hopes of discharge.

Some of the most basic future goals and plans that many patients held prior to their admission to the sanatorium were not viable options according to their physicians. For instance, women in the sanatorium were often discouraged from making plans of marriage and having children. Indeed, the advice given to Seagrave by her treating physician was to avoid taking any such chances, for "lungs do not heal permanently for a long time, and marriage with its adjustments to a new environment, and the probability of

[173] MacDonald, 239–240.
[174] MacDonald, 239–240.

childbirth, might be factors which would soon undo all...improvement...."[175] Patients in the sanatorium were essentially being told that they must adopt a sedentary life not only for the duration of their sanatorium stay, but for life. Physicians had begun to believe in the benefits of rest to such a degree that activity, even after the patient was discharged, was thought to be a risk too large to take. Had Seagrave lived prior to Koch's discovery of the tubercular bacilli, in all likelihood she would have never received such advice. In fact, according to Sheila Rothman, physicians of the nineteenth–century would have never advised a woman to refrain from having children, for they assumed that she would never accept such advice.[176] As Rothman points out, the sentiment of the time was that "bearing children was a woman's duty, and medicine had no business in abrogating it."[177] But with the rise of laboratory medicine, and the view that medical professionals were the experts in the matters of health and disease, physicians took greater license in controlling patients' lives, and, for the most part, patients accepted it.

For the men and women who held jobs prior to entering the sanatorium, their career paths were often abruptly cut off upon admission. Indeed, this fact often caused great concern and worry, especially for those who had a family and children to support.[178] But besides the obvious economic worries of making ends meet, cutting off one's career essentially meant radically disrupting a patient's life plan, the pursuit of which largely shapes one's identity.[179] For instance, Smith was left floundering and aimless for a great

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[175] Seagrave, 177.
[176] Rothman, 107.
[177] Rothman, 107.
[178] Bryder, 211ff.
[179] Heidegger, *Being and Time*, 185–186. This idea that one's personal identity is shaped both by one's past as well as one's projected future echoes in a wide array of literature today. Those involved in literary circles certainly have a great appreciation of viewing human life as a narrative. Common to this idea of narrative is that our life stories usually begin within a given

deal of her stay after her doctor advised her that "[she] must give up all thoughts of becoming a nurse."[180] Unfortunately, in the sanatorium, Smith did not have a plethora of options to replace her goal of being a nurse.

Advising someone to make a career change due to an illness was not something unique to the medical practice of the early twentieth–century. Like their tuberculosis counterparts, consumptives of the nineteenth century were also dissuaded from pursuing certain careers. As Rothman points out, men who had the propensity to pursue a career in academics were highly discouraged from doing so because a bookish, intellectual career was considered to be detrimental lifestyle, especially for someone who had the fate of a poor constitutional endowment working against him. Physicians of the nineteenth–century thus encouraged many consumptive patients (for the most part, only men) to pursue a more active lifestyle, of farming or sea–voyaging.[181] It is out of this nineteenth–century humoral thinking about consumption that we see consumptives, known as "health–seekers," who traveled to the dryer climes of Western America, adopting the lifestyle of rugged frontiersmen.

But the demands made on the sanatorium patients were far more extreme. For while consumptives were advised to give up their dreams of certain careers, they, unlike their twentieth–century counterparts, were nevertheless encouraged to remain active. As

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family and in a given socio-cultural context, elements which are beyond our own choosing or awareness. See, for instance, Howard Brody, *Stories of Sickness* (New Haven: Yale University Press, 1987), 44. Heidegger calls this phenomenon "thrownness." It is this background or "introduction" to our life stories which greatly shapes our ranges of possibilities throughout the rest of our narrative lives. But, as with any story, our lives are constantly in a state of unfolding, and thus the field of possibilities are always changing. As if they were ballroom dancers, the past and future are closely connected but with the future always taking the lead. In a sense, then, as human beings, we are positioned at the axis around which the past is constantly being reinterpreted in light of the future possibilities.

[180] Smith, 24.

[181] Rothman, 29–45.

"health–seekers," they were encouraged to undertake a new lifestyle by their own volition—a lifestyle which mimicked that of the most healthy and robust persons. They were not told to stop making plans; rather they were advised to change course, to alter the trajectory of their projections. Sanatorium patients, in contrast, were told to put all of their plans on hold and primarily to live by the golden rule of rest. To be sure, tuberculars and consumptives shared the overarching goal of becoming well again, but those in the sanatorium had to take it lying down. Moreover, while the consumptives could define themselves as sea voyagers, farmers, mothers, or health–seekers, their tuberculosis counterparts simply had to define themselves as patients.

Thus for many of sanatorium patients it was not necessarily the feelings of sickness to which they had to become accustomed, but rather it was the totally new context and environment in which they were supposed to live their lives. Discouraged from taking on the normal daily responsibilities of maintaining a household or holding a job, they had little other choice but to narrow their horizons to the goal of taking the cure so well that they could enjoy a speedy recovery and discharge.

CHAPTER 4
THE TEDIUM OF TB: SANITORIUM TIME

Many contemporary historians of tuberculosis and the sanatorium movement in the United States and Great Britain find little of historical use in Thomas Mann's *The Magic Mountain*. Bryder explicitly sets herself apart from Mann by entitling her book *Below The Magic Mountain*, wording which is used to highlight the fact that her story is about "ordinary sufferers" rather than the wealthy elite who took their cure in the luxurious sanatoria of the Swiss Alps. [182] The problem with Mann's novel, according to Bryder, is that, as a book which has largely shaped the popular understanding of life in the sanatorium, it is has perpetuated the false notion that tuberculosis was a disease of romance. In Bryder's mind, there was nothing positive about having tuberculosis, especially at a time of wide–spread stigmatization and mandatory confinement. In a similar vein, Rothman points out that, in most ways, the American sanatorium experience was fundamentally different than the account given by Mann, for in *The Magic Mountain* "fact mingles with fiction in a way that...obscures reality." Like Bryder, Rothman also takes issue with Mann's title, arguing that in respect to the American experience, it is an "utter incongruity [to] invok[e] a term like magic, when profound unhappiness, disappointment, and despair were the dominant emotions [of the sanatorium]."[183]

To be sure, the American sanatorium experience of the twentieth–century belies most romantic notions of tuberculosis—what most patients lived through was anything but exotic, uplifting or exciting. Moreover, the relevance of Mann's novel to the American experience is surely questionable given the fact that Mann's Davos sanatorium was situated in the Swiss Alps, catered to the affluent, and closely followed the

[182] Bryder, 200.
[183] Rothman, 226–227.

Brehmerian rather than the Trudeaun philosophy of treatment. But despite these differences, there is one very important aspect of the sanatorium experience that Mann's novel and the American autobiographies share: the patients' constant concern with time. It is in this respect that Mann's description of the strange character of temporality in the sanatorium is not merely fictional and not just a thought experiment, for the autobiographies of the American sanatoria indicate that Mann had touched upon a very real phenomenon.

Like Mann's protagonist Hans Castorp, patients in the American sanatoria felt so isolated from the outside world that the normal, objective indicators of time, such as calendars and clocks, no longer held much meaning. Inside the sanatorium walls, days became dominated by the patients' subjective sense of time. Moreover, because of the regime of prolonged bed rest and its effect of constricting their future possibilities to becoming well, patients became obsessed with time, for it was seen as an obstacle which stood in the way of attaining their primary goal. Since most patients did not have a precise sense of how long they would have to remain in their beds before they would be discharged, they had to adopt a kind of holding pattern rather than strive toward the future. Or, as Mann describes it, they had to live in an "inelastic present," a life in which it was virtually impossible to measure any temporal progress being made toward the goal of becoming well again.

The Relativity of Time

A fictional account of sanatorium life, Mann's *The Magic Mountain* is largely a novel about time. [184] Voicing the novelist's own opinion, the narrator explains that "there

[184] See Wood for a more thorough discussion about how, in Mann's novel, time takes on many different levels of meaning. See Wood, 103–115. For example, the most famous chapter of *The*

are situations in life on earth, or circumstance of landscape, in which confusion and obliteration of temporal and spatial distances... is more or less natural and legitimate...."[185] For Mann, who had personal experience of visiting his tubercular wife, Katia, in the Davos Waldsanatorium, the sanatorium is most certainly one of these "landscapes," for it is a place where time takes on a wholly different character compared to the outside everyday world. [186] In fact, it is in this spirit that he titled his book *The Magic Mountain* (translated from the German *Der Zauberberg*), which, among many English–speaking academics, has often been taken to mean a place of magical enchantment—a fairyland where the residents take up a life a leisure. But looking at Mann's discussion of time, we find a much darker side to the meaning of "magic." For, in regards to time perception, Mann portrays the sanatorium as a soporific place where a "magical" spell is cast over one's sense of time, so that, in the end, objective measures of time outside the sanatorium are essentially nullified.

The autobiographies of the American sanatorium patients indicate that once they were admitted, they quickly lost touch with outside time. One can only imagine what it must have been like to leave the daily routine of the modern, industrialized society—where time is objectively measured to the minute by a clock, and one's life is marked by an almost constant activity of working and taking care of one's family—to enter a place

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Magic Mountain entitled "Snow," presents a provocative metaphor for circular time and death. For more about Mann's presentation of time in the chapter "Snow," see Nancy P. Nenno, "Projections on Blank Space: Landscape, Nationality, and Identity in Thomas Mann's *Der Zauberberg*," *The German Quarterly* 69, no. 3 (1996): 305–321. For the purposes of this chapter, however, I will be interpreting Mann's conception of time only as it relates to the patients subjective perceptions vis–à–vis their sanatorium lives.

[185] Mann, 536.

[186] In his biography of Thomas Mann, Donald Prater claims that Mann originally conceived of *The Magic Mountain* in 1912 when his tubercular wife, Katia, took up temporary residence at the Davos sanatorium in the Swiss Alps. See Donald Prater, *Thomas Mann: A Life* (Oxford: Oxford University Press, 1995), 89–92.

where one was supposed to assume a reclined position for a large majority of the day. At first, the switch in pace was disorienting. Trying to come to terms with her new routine using the measures of the outside world, MacDonald describes her first rest period in bed as a struggle in which she had to come to terms with sanatorium time. With a tone of exhaustion MacDonald writes, "I looked at my watch. One o'clock: an hour and a half to go [until it is over]."[187] For the remainder of the ninety minute rest period, MacDonald continuously looked at her watch, impatiently awaiting the end. Despite what her watch told her, MacDonald sensed that time was going much slower than she thought it should. Irritated with its slow pace, she asked herself, "how long was two hours anyway?"[188] The passage of time, which she apparently had not contemplated much in her pre–sanatorium life, suddenly came into question.

For many patients, losing touch with the hourly passage of time eventually translated into losing track of the days. With one day seeming like every other, McClintock admits that "the date, the days of the week, were never certain in my mind."[189] True to the accounts of other patients, McClintock claims that with this muddied, confused perception of time, "the days flew by with an amazing rapidity."[190] For some patients, the only thing that would distinguish one day from another would be the various weekly medical procedures. MacDonald claims that, "the days were all so exactly alike and followed each other with such monotonous regularity that....I knew them only as 'gas' day, bath day, fluoroscope day, visiting day, supply day or store

[187] MacDonald, 74.
[188] MacDonald, 76.
[189] McClintock, 109.
[190] McClintock, 109.

day."[191] While MacDonald intellectually knew that there was a measured time of the outside world passing by, she was so "divorced from normal living" that it was difficult for her to consistently care about such measures.[192]

Once they had become immersed in the sanatorium routine, many patients felt that common indicators of time, such as clocks or calendrical days of the week, had no usefulness and meaning. Describing what is was like to live in the sanatorium in a letter to a friend, Seagrave writes, "talk about a well–regulated life! A...Swiss watch can't even begin to compete with us."[193] In an almost surreal way, patients like Seagrave began to feel as if they were more regulated than the measurements of time itself. Understandably, they began to trust and rely on the sanatorium routine more than any other indicators of time. Voicing an opinion similar to Seagrave's, Smith writes, "I began to really live the routine which eventually told the time for me so accurately that for years I never had the need of a clock."[194] Patients felt that they had little need for clocks or calendars because their daily lives were completely determined by the medical professionals who had complete control over the sanatorium schedule.

Because outside measures held little weight inside the sanatorium walls, within the same autobiography, it is often the case that a patient's perception of the cadence of time toggles back and forth between quickness and slowness. For example, although MacDonald found her first rest periods to be a drudgery, she documents that, on the whole, her first two weeks at the sanatorium were a period when time "went whizzing by.

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[191] MacDonald, 164. For more on patients measuring the days by medical procedures, see Smith, 166.
[192] MacDonald, 164.
[193] Seagrave, 60.
[194] Smith, 30.

Everything was new, everything was interesting...."[195] Here MacDonald attributes her experience of time moving quickly to the novelty of her situation—she had a new routine to learn, new people to meet and a new role to assume. Similar sentiments correlating novelty with swiftness of time can be found in Mann's novel. Likening the initial sanatorium stay to a trip, the narrator claims that "the first few days in a new place have a youthful swing to them, a kind of sturdy, long stride."[196] That is, with any change of scenery, even if it is in a sanatorium, one's sense of time takes on a youthful vigor, a rebirth, if you will, making time "fly by."

But such a sensation rarely lasts, especially in the sanatorium. Indeed, in stark contrast to her sentiments about her initial two weeks as a patient in the sanatorium, as a seasoned patients of two months, MacDonald writes, "I knew the routine....This made the time move with glacial slowness, made me even more restless and crotchety. Things which I had grown to accept as part of being institutionalized suddenly became unbearable...."[197] With every day being predictable, time became almost oppressive. In the sanatorium, there was little opportunity for a rebirth of one's sense of time once the initial novelty of the sanatorium life wore off. Because of the regularity of sanatorium operations, there was little if any noticeable change from one day to another. Prolonged bed rest and the sanatorium habits and routines had a deadening effect on the patients' sense of time; days became dull and monotonous, and time began to drag.

However, while some patients found that the boredom of the sanatorium routine made time seem to drag, other patients suggest that the routine had the opposite effect. For instance, Smith writes, "paradoxically enough this routine, whose sameness I had

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[195] MacDonald, 107.
[196] Mann, 102–103.
[197] MacDonald, 168.

found so infinitely wearisome, ended by making the days pass with amazing swiftness."[198] Although Smith admits that the routine may have been boring on a day–to–day basis, on the whole, the monotony had the effect of swallowing up the passage to time. In fact, Ross speculated that the routine was instituted by the medical professionals precisely for the purpose of making the "days move swiftly."[199]

In the end, the effect that the context of the sanatorium had on temporal perception reveals the powerful relatedness between space and time—not in an objective, empirical sense, but as that which is experienced by a perceiving subject. The confining physical space of the sanatorium, with its regulations and rules restricting freedom, led patients to experience time as if it, too, were constricted, in meaning, in usefulness, and in passage. Describing the intersection of time and space as it relates to the sanatorium, the narrator of Mann's novel writes that "time drowns in the unmeasured monotony of space."[200] Sanatorium space had a way of making time something very alterable. In such a place, it was possible to lose measurable time to such an extent that there seemed to be nothing "actual" about time.[201] Or as Castorp explained to his cousin Joachim, sanatorium time was so yielding that it could pass "quickly and slowly, just as you like."[202] Patients in the sanatorium were so cut–off from the outside world, that for them, time was something wholly relative to their own perceptions.

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[198] Smith, 46.
[199] Ross, 90.
[200] Mann, 537.
[201] Mann, 93.
[202] Mann, 14.

The Obstacle of Time

Although time was relative for sanatorium patients, for the most of their stay it was perceived to pass slowly. For, having to remain in bed completely inactive, they had no means by which to make time seem to pass more quickly through engaging in activities. The patients themselves were aware of this fact and they hungered for any degree of activity which would allow them to forget time. As MacDonald writes, "any change was welcome," for any alteration in the bed rest routine had the effect of making time go by more quickly.[203] Likewise Smith writes, "the basic pattern of my days had become so set that when my bed...collapsed one afternoon and catapulted me onto the floor, I was delighted. *Anything* for a change."[204] Even the most banal events lessened the tedium of tuberculosis.

Since sanatorium patients were precluded from taking on any activities, they were essentially in a perpetual state of waiting—waiting for a change, waiting to be given a clean bill of health, and ultimately, waiting to be discharged to return to their former lives. And, as is indicated in *The Magic Mountain*, waiting in the sanatorium "mean[t] seeing time and the present not as a gift, but as a barrier...."[205] Thus many patients became fixated on time, for it was that which not only precluded them from attaining their goals, but which also made their sanatorium stay virtually unlivable. For example, Smith writes, "I could not bear these days that were merely 'time to kill.'"[206] For Smith, when time went slow, it was the enemy, something which she needed to ward off. She

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[203] MacDonald, 130.
[204] Smith, 92, emphasis in original. See also MacDonald, 155.
[205] Mann, 236.
[206] Smith, 56.

wanted to abolish time, to make time pass more quickly than her sanatorium lifestyle would permit.[207]

Ultimately the patients' constant state of waiting contributed to the their feelings of psychological unease, restlessness, and anxiety. Or as Heidegger once described it in a lecture on the phenomenological experience of boredom, "passing the time has a peculiar character of a fluttering unease that brings...impatience with it. For what happens in becoming bored is that our unease...does not allow us to find anything that could grip us, satisfy us or let us be patient."[208] Having little–to–no control over their circumstances, sanatorium patients could rarely find anything which would help them pass the time. Indeed, if "passing the time is a way of taking action against the dragging of time that oppresses us," then sanatorium patients were left with little means to combat the oppressor.[209]

The "Inelastic Present"

The key to understanding the cadence of sanatorium time, then, is to appreciate the fact that, in living every day in the same bed without any change, patients did not have any clear indicators of making temporal progress toward their primary goal of becoming well. Mann gives a very clear description of what such an experience must have been like through his character Castorp, who upon a relapse, underwent several weeks of complete bed rest.

> It is always the same day—it just keeps repeating itself. Although since it is always the same day, it is surely not correct to speak of "repetition." One should speak of monotony, of an abiding now, of eternalness. Someone brings you your midday soup, the same soup they brought you yesterday and will bring you again

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[207] Martin Heidegger, *The Fundamental Concepts of Metaphysics: World, Finitude, Solitude* trans. William McNeill and Nicholas Walker (Indianapolis: Indiana University Press, 1995), 93.
[208] Heidegger, *The Fundamental Concepts of Metaphysics: World, Finitude, Solitude*, 94.
[209] Heidegger, *The Fundamental Concepts of Metaphysics: World, Finitude, Solitude*, 99.

> tomorrow....The tenses of the verbs become confused, they blend and what is now revealed to you as the true tense of all existence is the "inelastic present," the tense in which they bring you soup for all eternity.[210]

Because Castorp had no indicators of time, he became stuck in constant state of the present, where even the basic premise of temporal progression could no longer be taken for granted. The homogeneity of his bed rest days made every day seem so much alike that it was difficult for him to "separate the 'now' of today from that of yesterday, or the day before yesterday, or the day before that." With the days blurring together, Mann claims that Castorp's sense of a present "now was apt, even likely, to muddle its present with a present that had prevailed a month or a year before, and fuse into an 'always.'"[211]

Powerful echoes of this idea of the "inelastic present" can be detected in the American sanatorium narratives. Patients consistently write of the monotony of their days. For instance, after two months, MacDonald writes, "I knew the entire Bedrest Hospital routine by heart and could tell exactly what was going to happen every minute of every day," leaving her with little to distinguish one day from the next.[212] Even what would seem to be a fundamental change according to sanatorium standards did not effect the patients' pervasive sense of monotony. Having been switched to a new room in the sanatorium, with dashed hopes of finding a renewed sense of time in a new environment, Ross languorously writes:

> The change of [rooms] meant no particular change in my daily routine. I kept right on with the usual formula: the waking up on schedule; the meals at their appointed hours; the long rest periods faithfully observed; the comings and goings of the doctor and the nurses; the daily questioning of the doctor and his unsatisfactory answers; day after day, week after week, month following month, the seasons changing but no break in the rigid discipline.[213]

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[210] Mann, 180.
[211] Mann, 536.
[212] MacDonald, 168.
[213] Ross, 101.

The tone of Ross' account indicates that he was experiencing a similar sense of drudgery and monotony that Castorp does in Mann's novel. In fact, Ross' experience of time was not even effected by the obvious progress of time that he saw outside his window. He was caught in the web of the "inelastic present" to such an extent that of was the change of seasons did not matter, for his days inside the sanatorium walls were the same regardless of seasonal changes.

In comparison to the outside world, it was as if time in the sanatorium had stopped. And outside indicators of a change in time had little effect on sanatorium patients. For instance, MacDonald claimed that she could estimate the admission year for every patient just by his or her dress. She writes, "The degree of out–of–datedness [in dress and hair style] varied with the length of time the patient had been at the Pines and what had been in vogue when she entered."[214] Once patients were admitted into the sanatorium, it was as if they stepped into a temporal vacuum.

What was ultimately at stake, though, in living a life of prolonged bed rest and experiencing a perpetual "inelastic present," was that there was no way for patients to measure progress being made toward their goal of getting well. After seven consecutive weeks of bed rest, Smith writes, "the weeks rolled by," until she finally asked her doctor: "Hadn't I been in bed long enough?" To that her doctor simply replied, "You must rest a long, long time." With such a prognosis, Smith had no clear way of measuring her progress toward her one goal of becoming well again. Not only was she unsure about what constituted wellness from her physician's perspective, but she was given no

[214] MacDonald, 154.

milestones to look for along the way. Instead, she was simply left wondering how long a "long, long time" could be.[215]

That medical professionals did not candidly discuss timetables or prognosis of recovery with the patient was common within most sanatoria. Most likely, physicians kept concrete discussions about prognosis to a minimum because there was a pervasive belief on the part of the medical staff that vagueness was in the best interest of the patients. As Rothman points out, the staff in the sanatorium had every reason to avoid discussions of recovery, for "telling those who were not making progress of their likely fate was too painful, and those who were on the mend might be tempted to leave too soon or stop adhering to the regimen."[216] But whatever the reasoning behind withholding information, the inexact terminology used by medical practitioners had the indisputable effect of creating a type of time warp in which patients had to accept the unknown and put virtually all of their life plans on hold.

To make matters worse, since many of the patients had a sense a well–being for a large majority of their stay, they often did not have a good sense of that for which they should be aiming. Smith describes the struggle of having no concrete goal during her rehabilitation in the following way, "it seemed to me that convalescence was every bit as much of a chore as illness itself, and much more boring. When I was severely ill, I was a least struggling with something immediate and tangible...."[217] Realizing that their subjective feelings were not considered reliable indicators of the true nature of health and sickness, patients, like Smith, did not have any real or "tangible" indicators of what they

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[215] Smith, 23.
[216] Rothman, 244.
[217] Smith, 132.

were fighting, or whether or not they were winning the battle. The uncertainty about how they should go about attaining their goals of well–being and discharge was acute.

Because patients could not measure their progress, and had to put their plans on hold, they began to treat days, months, and years with little regard, for not being able to accomplish anything, the passage of time inside the sanatorium had little meaning. Mann repeatedly points out the way patients in the sanatorium conflated years into minutes. At the beginning of the novel, Castorp, who had just arrived to the sanatorium was told that "three weeks are almost nothing for us up here [in the sanatorium], of course, but for you, just here on a visit and planning to stay a grand total of three weeks, for you that's a long time."[218] In line with Mann's description, one of the first impressions that MacDonald had of the Firland sanatorium was the odd way in which sanatorium patients spoke about the future. MacDonald writes, "the patients spoke of two, three, and five years with a casualness usually associated with minutes."[219] Once a patient was in the sanatorium long enough, such an odd tendency frequently became the norm. After a month of bed rest, Smith claims "I measured my hopes for the future always in terms of 'next year'—a practice which became habit."[220] Knowing that the immediate days and weeks would most likely be taken in bed, Smith began to expect change only in the years to come. In a way, talking about years as if they were minutes was a means for sanatorium patients to avoid dashed hopes, to avoid the disappointment that tomorrow would not bring something new.

From the patients' perspective, having nothing by which to gauge their days, weeks or overall progress was something altogether unwelcome. Speaking for many

[218] Mann, 7.
[219] MacDonald, 62.
[220] Smith, 55.

patients, Smith writes, "The endless passage of days with nothing tangible to show for it troubled me more and more. What was I accomplishing—I wanted to accomplish so much."[221] Patients, like Smith, were put in the paradoxical position of wanting to live healthy, teleological lives, in which time progressed, but, at the same time, wanting to adhere to the sanatorium regime which restricted such a life in the hopes for a cure. The sanatorium regime was thus not at all an easy treatment to endure. No other patient sums up the sacrifice better than Ross who writes, "...the most difficult thing for a patient to accept is the fact that he must give immeasurable time—weeks, months, years if need be––to his cure."[222]

[221] Smith, 55.
[222] Ross, 89.

CONCLUSION

Despite the medical advances made during the 1940 and 1950s and the discovery of such antibiotics as streptomycin and isoniazid, tuberculosis is still with us today. In fact, recent evidence indicates that tuberculosis is on the upswing, with various drug-resistant strains emerging.[223] Several studies have shown that much of the drug resistance to tuberculosis can be traced to the noncompliance of patients taking their antibiotics.[224] Thus today in the United States, the preferred way to control tuberculosis is through directly observed therapy (DOT), a program in which patients voluntarily received their daily or twice–weekly antibiotics under the direct supervision of an outreach worker. Under DOT, patients can received their medications at virtually any location: at the clinic, in their homes or at their workplace.

But although the DOT program has been rather successful in overcoming noncompliance rates, there are still some patients with tuberculosis who either refuse or simply fail to take their medications. In cities and states with particularly high rates of noncompliance, such patients are often forcibly detained in hospital wards until they are cured, a practice which is hauntingly similar to the compulsory confinement to sanatoria in the early part of this century. Yet looking at the issue of noncompliance today through historically–informed eyes, one can see that much of the problem still lies in the fact that some patients who do not feel sick have difficulty believing that they are sick or that their sickness is threatening enough to warrant medical intervention. For instance, Barron Lerner recounts a recent case of noncompliance in New York city in which a 34 year old

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[223] For instance, according to Lerner, the annual number of new cases of tuberculosis in the United States increased by 20 percent between 1985 and 1992, from 22,101 to 26,673. (Lerner, 166) In New York city alone, there was an increase of 2,000 cases between the years of 1980–1991. (Seale and Pattison, 57)

[224] Lerner, 167.

homeless man with tuberculosis refused to take his medication because he did not believe he had a contagious, life–threatening disease.[225] While laboratory medicine and germ theory have been with us for over a century now, we still cannot take for granted that everyone accepts the fact that one can be sick without feeling sick.

Moreover, just as tuberculosis is very much a disease of the present, prolonged bed rest is still frequently prescribed today. For instance, women with high–risk pregnancies are often advised to remain in bed, for many physicians believe that a reduction in activity helps to keep the uterus from contracting. Indeed, some women have to endure up to four months of complete bed rest. Interestingly, like the sanatorium patients with incipient, asymptomatic tuberculosis, women with high–risk pregnancies often have to endure prolonged periods of rest despite their feelings of well-being. For this reason, there are striking similarities between the contemporary narratives of pregnant women who have undergone prolong bed rest and the sanatorium narratives—both convey similar feelings of boredom, isolation, as well as concerns about future life plans and goals.

A study such as I have undertaken here should keep us from losing sight of the fact that prolonged bed rest can have serious side–effects on the human psyche. To be sure, for some of us it is tempting to think of bed rest as kind of vacation from the worries and tasks of everyday life. And perhaps some physicians today who (with the best interest of their patients in mind) prescribe prolonged bed rest are still working under the same premise that Trudeau articulated a century ago: "I know I have hurt nobody by rest,

[225] Lerner, 167–168.

but I am quite sure I often have by allowing them to exercise."[226] But we cannot take the goodness of prolonged rest for granted. For as we have seen from the sanatorium narratives, bed rest was so invasive at times that it altered how patients related to the world around them. In most cases, patients in the sanatorium endured such a deep sense of isolation that they felt alienated from their families and friends as well as from their former lives as healthy individuals.

[226] Trudeau quoted in Pratt, "The Development of the Rest Treatment in Pulmonary Tuberculosis," 65.

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