HEALING THE FRONTIER:

CATHOLIC SISTERS, HOSPITALS, AND MEDICINE MEN

IN THE WISCONSIN BIG WOODS, 1880-1920

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by

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The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

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For Mary, who insisted that the doctors never knew what they were doing anyway…

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ABBREVIATIONS

AMA	American Medical Association
APHA	American Public Health Association
BCIM	Bureau of Catholic Indian Missions
FDA	Food and Drug Administration
HE	*Hayward Enterprise*
HR	*Hayward Republican*
LCO	Lac Court Oreilles
NATA	National Anti-Tuberculosis Association
NWLC	North Wisconsin Lumber Company
NWN	*North Wisconsin News*
OIA	Office of Indian Affairs
PMA	*People's Medical Advisor*
SBOH	Wisconsin State Board of Health
SBOHR	*Annual Report of the State Board of Health of the State of Wisconsin*
SMS	State Medical Society of Wisconsin
WATA	Wisconsin Anti-Tuberculosis Association
WHS	Wisconsin Historical Society
WMJ	Wisconsin Medical Journal
WMA	Wisconsin Medical Association
WPA	Works Progress Administration
WSB	Washburn-Sawyer-Burnett County Medical Society

INTRODUCTION

> "Health is essential to the accomplishment of every purpose; while sickness thwarts the best intentions and loftiest aims. We are continually deciding upon those conditions which are either the source of joy and happiness or which occasion pain and disease. Prudence requires that we should meet the foes and obviate the dangers which threaten us, by turning all our philosophy, science, and art, into practical *common sense*."[1]

On October 13, 1896, 23 year-old Minnesota State law student Albert Sabean came home to Hayward, Wisconsin only six weeks after beginning his studies. He had ambitiously intended to complete the normal three years' coursework in only one year, but that plan was cut short by illness. Albert remained bedridden at his parents' home for three full months, after which he went west to try to effect a cure for his "hemorhoids of the lungs." After a year of rest and recuperation, Albert was finally able to return to his studies. He completed law school successfully, and by 1900, he had formed a business partnership back home in Hayward with the local district attorney.[2] The episode passed into memory, although it had cost him a year of his life, during which the *Hayward Republican* [hereafter *Republican*] was "pleased" to note that Albert's "several attacks of bleeding at the lungs" did not constitute a "case … of a serious nature."[3]

Over a hundred years later, I talked about Albert with my aunt, who lives in another northern Wisconsin community, as I was explaining the new directions my dissertation research was taking. Initially interested in the development of health care

[1] R.V. Pierce, M.D., *The People's Common Sense Medical Adviser in Plain English: or, Medicine Simplified*, 46th ed. (Buffalo, NY: World's Dispensary Printing Office and Bindery, 1895), 9.

[2] J.G. Adams, *History of Education in Sawyer County, Wisconsin* (McIntire, Iowa: M.E. Granger, 1902), 250.

[3] *Hayward Republican* [hereafter *HR*], 15 October 1896.

delivery systems in northern Wisconsin during the Progressive Era, I had found myself increasingly drawn back into the Gilded Age and the murky waters of frontier health care. My aunt's response to Albert's story and to my lengthy description of my dissertation research was short and to the point: "There was no health care up here back then." As my research progressed, I found out that her response was one of two that I invariably got from people living in the area when I told them what I was researching.

This first reaction – that there was no health care in northern Wisconsin at the end of the nineteenth century – has a history of its own. Americans' conception and expectations of health care in the twenty-first century continue to be defined by structural developments made in the 1920s and 1930s, when Progressive and New Deal health care reformers created a modern health care doctrine. According to these reformers, a health care system required:

- Practitioners who had received a standardized education and who were licensed to practice by the state.
- Facilities that conformed to established criteria of cleanliness and orderliness.
- Pharmaceuticals that had a consistent quality and that were approved by the state for distribution.
- Scientific foundations that supported the standardized education, established the criteria of cleanliness, and developed the pharmaceuticals.

And

- Access to care. Those practitioners, facilities, and pharmaceuticals and the scientific research they represented had to be available at a reasonable

> cost and located within a reasonable distance of those people whom they served.

In other words, Progressive Era and New Deal reforms ensured that American health care would be firmly connected to the state and to the American educational system.[4] There would be little room in this strict set of guidelines for any form of heresy, including what twenty-first century Americans would call "alternative" health care.

Under this set of requirements, there certainly was no health care in northern Wisconsin before the twentieth century. However, there were also no local progressive health care reformers enforcing the developing set of standards. Most of the folk who lived, loved, and died in Hayward and its surroundings in the late 1800s and early 1900s professed a different therapeutic doctrine, one that was based on traditional wisdom and on the reputations of the communities' healers.

The second response to my dissertation topic that I heard from people living in Hayward was: "Good! Maybe you can do something about the terrible health care system we have here now." This reaction is also informed by the health care gospel of early twentieth-century reformers, in part because the doctrine itself is ambiguous. Health care may be available but not particularly easy to access or afford, whether or not

[4] For studies of the creation of the modern American health care system, see: E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979); James G. Burrow, *Organized Medicine in the Progressive Era: The Move toward Monopoly* (Baltimore: The Johns Hopkins University Press, 1977); John Duffy, *From Humors to Medical Science: A History of American Medicine*, 2nd ed. (Urbana: University of Illinois Press, 1993); ———, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1990); Judith Walzer Leavitt and Ronald L. Numbers, ed., *Sickness & Health in America: Readings in the History of Medicine and Public Health*, 3rd ed. (Madison: The University of Wisconsin Press, 1997); Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Basic Books, 1987); William Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York: Oxford UP, 1987); and Paul Starr, *The Social Transformation of American Medicine* (USA: Basic Books, 1982).

one has insurance. Pharmaceuticals may conform to a standard of quality and be supported by research, but they still might not be effective. And of course, the assumption of the doctrine is health, but life itself has a mortality rate of exactly 100 percent. In other words, no matter how much health care has *improved*, there is still plenty of room for more *improvement*.

Certainly, Haywardites of the late 1800s and early 1900s saw room for improvement in their health care system. The more I read about them and their lives, however, the more I realized that they were not particularly pessimistic about their situation, even though they seemed to be doing their best to make life's 100% mortality rate even higher. They were, by twenty-first century standards, exceedingly unhealthy with little hope of survival. In 1888, Hayward reported to the Wisconsin State Board of Health (SBOH) that at least 100 residents had developed whooping cough over the prior year; that morbidity rate of 4% dwarfed the 0.06% rate that Milwaukeeans experienced that same year.[5] From January 1, 1905 to September 30, 1906, the death rate from tuberculosis in Sawyer County, the county of which Hayward is the seat, was the fourth highest in the state; Sawyer's mortality rate of slightly over 20 per 10,000 barely trailed that of Milwaukee, LaCrosse, and Racine counties.[6] And in 1915, Sawyer's infant mortality rate of 106.0 per 1,000 live births dwarfed the rates of the other rural counties in Wisconsin and was, in fact, almost as high as the worst of the urban counties.[7]

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[5] *Annual Report of the State Board of Health of the State of Wisconsin* [hereafter *SBOHR*], (Madison, WI: E.B. Bolens, State Printer, 1888), 12.

[6] 21st *SBOHR*.

[7] Table 33, 26th *SBOHR*. The next highest rate was a 96.8 in Kewaunee – this is still a number that is shocking by twenty-first century standards. Among counties that contained large cities, Sawyer's infant

Yet when asked to report about their community's general health, Haywardites insisted that they lived in a relatively healthy region. Dr. Trowbridge, who was Hayward's health officer for many years, was optimistic in his reports to the SBOH as a matter of routine. In 1887, for example, he stated:

> An extensive epidemic of Measles occurred during the winter, and there was [sic] a large number of cases of Pneumonia; with the exception of these and numerous cases of Diarrhœa and a moderate number each of Dysentery and Cholera Morbus, we have not had a great amount of sickness.[8]

The local newspaper editor tended to agree; periodically in his columns of local news tidbits, he asserted that the "citizens of Hayward can congratulate themselves on escaping contagions by living in one of the healthiest … towns in Northern Wisconsin."[9] And when neighboring communities developed epidemics, the editor would cajole residents to keep the streets clean; in a typical example of his urging, he stressed that "Hayward has always had the reputation of being one of the most healthy towns in the state and it will be to our advantage to keep up that reputation."[10]

I knew that nineteenth century Haywardites had a therapeutic doctrine that differed greatly from the health care doctrine of the late twentieth and early twenty-first centuries. What became increasingly apparent in my research was that Haywardites also had radically different basic concepts of health and sickness in the 1880s and 1890s than Americans have today. The routine optimism of the health officer and of the other

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mortality rate would still have been rather high; only three of those "large" counties had higher rates, while fifteen had lower rates.

[8] 11th *SBOHR*, 207.

[9] *HR*, 6 July 1894.

[10] *HR*, 7 September 1896.

Haywardites I studied began to make more sense when I realized that it was a consequence of those distinctive notions of health and sickness.

Albert Sabean was clearly sick when he fled home from college in 1896. He was suffering, and he took steps to ensure that suffering would end, including remaining on bed rest and taking a trip to spend a winter in the Rockies. Haywardites, in general, also recognized Albert as being sick; the newspaper report, after all, defined his "bleeding at the lungs" as a condition requiring some sort of treatment. However, an attack of bleeding lungs occurring in a 23-year-old American a century later would likely result in hospitalization and prolonged pharmaceutical treatments. The expectation of the American community regarding bleeding lungs changed over that hundred years. The definition of that illness – tuberculosis – has also changed, while the clinical expression of the disease, the blood that is coughed into the handkerchief, remains the same. An illness that was "not of a serious nature" is now something deemed very serious indeed.

Illness, then, is a condition that is malleable and culturally defined. The difference between a definition of illness in modern America and in a radically different culture can be extreme. For example, a young American who has blood in his urine after traveling in parts of Africa might be diagnosed with schistosomiasis, a parasitic disease; a young African with the same clinical expressions of disease would be considered as showing indications of health and would not be diagnosed with an illness at all.[11] Illnesses that were recognized as such in Gilded Age and early Progressive Era Hayward

[11] Severe infection with a blood fluke, *Schistosoma haematobium*, produces ulcerations in the bladder that leech blood into the urine. "This is so common an occurrence that in many parts of Africa it is considered to be a kind of male menstruation" and a "marker of impending sexual and social maturity." Robert S. Desowitz, *New Guinea Tapeworms and Jewish Grandmothers: Tales of Parasites and People* (New York: W.W. Norton, 1981), 104-14.

are typically recognized as illnesses in America today; the difference is one of degree. Bleeding at the lungs was an illness then, as it is now. However, the community had expectations regarding appropriate levels of physical and mental vigor that informed their definition of illness, their understanding of the causes of illness, and the suitable treatments for illnesses – expectations that were unique to the time and place.

And if "illness" is malleable and culturally defined, then "health" must also be culturally defined. Haywardites' nineteenth century standards of health depended on functionality, on the ability to engage in typical daily activities, such as working, eating, sleeping, and visiting with neighbors and friends. They did not require the absence of disease, a standard subscribed to by my aunt, who was trained as a nurse during the Cold War when the use of antibiotics to eliminate germs was equated with the elimination of strains of communist thought in American society. And while 19th century Haywardites, like 21st century Americans, appreciated and welcomed the presence of positive signs of health like taut muscles, thick hair, white teeth, and sexual vigor, the lack of those signs did not always indicate a corresponding lack of health, as it does for many Americans in the twenty-first century.

The study of changing definitions of health and sickness has not been a subject fully explored by historians; rather, it is a subject that historians have generally left to sociologists and anthropologists. Moreover, work on this topic has tended to be ignored by historians who have written about the development of American health care systems.[12]

[12] For some anthropological investigations into the changing definitions of health and disease, see: Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to Aids* (Ithaca: Cornell UP, 1988); and Robert A. Hahn, *Sickness and Healing: An Anthropological Perspective* (New Haven: Yale UP, 1995).

Works on the subject written or used by historians and focused on American society are notable in their exception and often center on stigma or on body image. Among those works, popular and academic, frequently cited by historians are Susan Sontag's *Illness and Metaphor,* Joan Jacob Brumberg's *The Body Project*, and Nayan Shah's *Contagious Divides.*[13] In addition, while activists and historians have long associated the environment with health and disease, only recently have historians begun to explore the associations Americans made between their changing environment and the *perception* of health or sickness. Notable among these recent works is Conevery Bolton Valenčius' *The Health of the Country*.[14]

A topic that historians have explored more fully is the establishment of the modern American health care system. Typically, historians have noted a line of demarcation between American health care before and after the Progressive Era, and they generally date that line to between 1900 and 1920. The general consensus among those historians is that American health care after the 1920s has been increasingly tied to the state and has steadily become more professional – that is, practitioners have become

[13] Susan Sontag, *Illness as Metaphor* (New York: Farrar, Strauss & Giroux, 1978); Joan Jacobs Brumberg, *The Body Project: An Intimate History of American Girls* (New York: Random House, Inc., 1997); and Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001). See also: Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States* (New York: 1985); Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Cambridge: Harvard University Press, 1988); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Pantheon Books, 1965); Vanessa Northington Gamble, ed., *Germs Have No Color Lines: Blacks and American Medicine, 1900-1945* (New York: Garland Publishing, 1989); and Alan M. Kraut, *Silent Travelers: Germs, Genes, and The "Immigrant Menace"* (Basic Books, 1994).

[14] Conevery Bolton Valenčius, *Health of the Country: How American Settlers Understood Themselves and Their Land* (Basic Books, 2002). Among the standard works exploring the relationship between the environment and health and sickness are: Rachel Carson, *Silent Spring* (Boston: Houghton Mifflin, 1962); Alfred Crosby, *America's Forgotten Pandemic: The Influenza of 1918* (New York: Cambridge UP, 1989); and William H McNeill, *Plagues and Peoples* (New York: Doubleday, 1977).

interconnected through formal organizations that regulate standards of and ability to practice.[15] Historians who study American health care before the advent of the progressives describe a system that was, at best, unorganized. Some practitioners were well educated, while others only received an informal apprenticeship. Some therapeutic practices had a scientific basis, while others had roots in traditional customs. Some treatments were effective in producing better health, and others were effective in rapidly producing life's 100% mortality rate. Generally, historians find in those murky waters the seeds of what would become a twentieth century health care delivery system, and they also find "alternative" or "natural" cures – therapies and therapists that Progressive and New Deal reformers pushed to the sidelines.[16]

One way of understanding how and why Americans pushed "alternative" cures aside, embraced a "modern" healthcare system, and changed their definitions of health and sickness is through an examination of this process in a frontier setting. A study that focuses on this type of venue – where social norms, the economy, and the government are not stable – can more easily reveal subtle cultural changes that often remain obscure in the anonymity of a large and long-established population. The value of frontier studies has long been accepted by historians. In 1893, Frederick Jackson Turner argued that the

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[15] See: James G. Burrow, *Organized Medicine in the Progressive Era*; and Paul Starr, *The Social Transformation of American Medicine*.

[16] See, for example: Jane B. Donegan, *Hydropathic Highway to Health: Women and Water-Cure in Antebellum America* (New York: Greenwood Press, 1986); Bruce Fye, *The Development of American Physiology: Scientific Medicine in the Nineteenth Century* (Baltimore: Johns Hopkins UP, 1987); John S. Haller, Jr., *American Medicine in Transition, 1840-1910* (Urbana: University of Illinois Press, 1981); Charles Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Madison: University of Wisconsin Press, 1980); Todd Savitt, *Medicine and Slavery* (Urbana: University of Illinois Press, 1978); and Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Alfred A. Knopf, 1990).

continuing process of settlement of the American frontier constantly renewed both democratic ideals and Americans' reliance on individualism. In short, he maintained that the process of frontier settlement was what created American institutions. Americans who lived on this "meeting point between savagery and civilization" were continually forced to modify their social, political, and legal procedures in order to survive in a changing environment. Customs that were European simply were not viable in this new and distinctive environment. Accordingly, the settlers quickly disposed of their old ways and developed, in their place, a culture that was uniquely democratic and individualistic – two features that Turner marked as being distinctly American.[17]

Turner's paper had a groundbreaking effect, both among historians and in the popular press, especially among Americans who feared that the disappearance of the American frontier spelled doom for their country's exceptionalism. By the mid-twentieth century, however, historians who were adherents to the new social history began to argue against this positivist interpretation of the frontier. These historians argued that the west was not settled but was conquered, and instead of fostering democracy and individualism, the expansion of Anglo-American culture devastated landscapes and destroyed existing societies built by Indians and Hispanics. And, the economic process of American settlement led not to a constructive work ethic but to a destructive capitalist egoism. Recently, historians have begun to argue that contact along a more broadly defined frontier, an area of borderlands, was not one of civilization and savagery or conqueror

[17] Frederick Jackson Turner, "The Significance of the Frontier in American History," in *Annual Report of the American Historical Association for the Year 1893* (Washington, D.C.: GPO and American Historical Association, 1894).

and conquered. Instead, this contact provided the opportunity for an exchange of cultures that gave birth to a third culture based in economic and cultural exchanges.[18]

This dissertation examines the murky waters of frontier American images of health and sickness as well as the development and application of an early Progressive Era doctrine of health care and argues that these definitions and developments were products of a cultural, economic, and intellectual borderland. I do this through an examination of the experiences of Albert Sabean's community, Hayward as well as the experiences of the "hidden" population near Hayward, the people who lived on the Lac Courte Oreilles (LCO) Indian reservation. As tribal lands were officially federal properties, Sawyer County's high morbidity and mortality statistics published by the SBOH did not include information about the Ojibwe who lived only fifteen miles away, at the LCO. Nor did Health Officer Dr. Trowbridge or the editor of the *Republican* consider the LCO population as part of the legitimate, reportable community. In the written record, the Ojibwe were truly "hidden." That population, however, held intricate ties with the people of Hayward and of Sawyer County at large; these ties were legal and social, religious and secular, cultural and political. In sickness and in health, the fortunes of Haywardites were united with the fates of the LCO Ojibwe. Because of these ties with

[18] For more about Turner, the frontier, and American exceptionalism, see: Ray Allen Billington and Martin Ridge, *Westward Expansion: A History of the American Frontier*, 5th ed. (New York: Macmillan, 1982); Patricia Nelson Limerick, *Legacy of Conquest: The Unbroken Past of the American West* (New York: W.W. Norton, 1988); Seymour Martin Lipset, *American Exceptionalism: A Double-Edged Sword* (New York: W.W. Norton, 1997); Gerald D. Nash, *Creating the West: Historical Interpretations 1890-1990* (Albuquerque: University of New Mexico Press, 1991); Richard White, *"It's Your Misfortune and None of My Own": A New History of the American West* (Norman: University of Oklahoma Press, 1991); ———, *The Middle Ground: Indians, Empires, and Republics in the Great Lakes Region, 1650-1815* (Cambridge: Cambridge University Press, 1991); Donald Worster, "New West, True West: Interpreting the Region's History," *Western Historical Quarterly* 18 (1987); and David W. Wrobel, *The End of American Exceptionalism: Frontier Anxiety from the Old West to the New Deal* (Lawrence: University Press of Kansas, 1993).

a population so dissimilar to mainstream America, a trouble-free advent of the canon of modern health care was not a foregone conclusion on the LCO. Nor was it inevitable that Haywardites would adopt a typically 20th century American definition of health or of sickness. At critical moments, individual Haywardites or individual Ojibwe made decisions that led to their community's eventual profession of faith in modern American health care, despite the failures that the system had and continues to have.

Access to health care was a basic tenet of the Progressive doctrine. Reformers endorsed state licensing and regulation as well as state support for research. However, they also assumed a *laissez faire* attitude towards health care expenses; they presumed that Americans would pay for their own care, either individually or through private insurance. As a group, the local Ojibwe represented a rare exception to this *laissez faire* attitude towards health care economy. Because the government officially regarded Native Americans who lived in the reservation system as having less than full citizenship and a corresponding lack of capability, the presumption of individual responsibility did not apply to them, as a group. Thus, while Haywardites struggled with the changing health and health care expectations, local Ojibwe struggled with the Office of Indian Affairs' (OIA) medical service and its bureaucratic application and misapplication of those changing expectations.

Because this dissertation focuses so closely on the population in Hayward and on the LCO, by definition it is a local study. And, since all communities are unique, at least to a degree, the experiences of these people should not be generalized and applied to all American communities that boomed during the Gilded Age and Progressive Era. Certainly, the interactions between the essentially immigrant community and the Ojibwe

reservation that it abutted add to this unique set of experiences. However, the ideas that Haywardites and the Ojibwe struggled with and the developing bureaucracy that ensnared them were not exceptional. The people of these communities transformed their ideas about health and sickness while Americans in general were doing the same. They made choices regarding health care that were constrained by similar circumstances and laws that constrained choices made throughout the country. They encountered the triumphs and shortcomings of Progressive Era reform with varying degrees of skepticism that many working class and immigrant communities across America shared. The successes and failures in health care systems that existed in Hayward and on the LCO between 1880 and 1920 reflected similar successes and failures that occurred across America at that time, and our experiences continue to reflect them, even in the early 21st century. A study of health care and of ideas about health and disease before and during the advent of the Progressive health care catechism illuminates the constructed nature of those ideas and the system. What is now has not always been, nor should it always be.

Chapter one, "Hospitals and Health Insurance in a Backwoods Community," focuses on the early development of Hayward and its infrastructure. Because Hayward was so remote and rural and because its government and much of its population were so unstable, early attempts by permanent residents to establish a standardized health care network failed.

Chapter two, "Frontier Medics: The Country Doctor, the Modern Physician, and Folk Healers" examines the practitioners who operated in Hayward from the late 1800s to the early 1900s and their relationships with each other. While later twentieth century medical practitioners were able to professionalize and to exclude "alternative" health care

providers from legitimate practice, many of the settled practitioners in early Hayward developed a symbiotic relationship that rested on respect – both respect for reputation and respect of territorial practice. Health care providers that threatened the livelihood of those settled practitioners were the ones who were excluded; exclusion or inclusion in the health care establishment rested on willingness to work well with others, not on compliance with any "official" health care doctrine. The absence of large numbers of health care providers as well as the general absence of enforcement of the little health-related legislation that existed ensured this elasticity.

Chapter three, "Sacred Teas, a Sisters' School, and an Indian Priest: Holism and Modernity Collide" explores the systems of care that operated on the LCO during the late 1800s and early 1900s. These systems of care begin with Midewiwin practices – religious and cultural rituals that placed great value in traditional remedies for illness while observing a holistic recognition of the connection between man, his environment, and his social relationships. The Midewiwin rituals corresponded well with the introduction of another holistic health care system that Catholic sisters brought to the LCO in the late 1880s. However, the arrival of a Catholic priest, who also happened to be Ojibwe, pushed the LCO population to turn from its close dependence upon traditional therapeutic remedies to a more general reliance on scientific medicine, which the United States Office of Indian Affairs (OIA) had brought to the reservation.

Chapter four, "Open Pores, Wigglers, and Demons: An Ecumenical Gospel of Germs" examines the transition among the populations of Hayward and LCO from a wide variety of beliefs in the causes of disease to the acceptance of the idea that all diseases are caused by germs. This new "gospel of germs" had to be wrapped in a mantle

of modernity, taught in schoolrooms, and evangelized from the pulpit. In short, the new theory had to be marketed to a public that was less than willing to convert from its traditional beliefs.

Chapter five, "Scarlet Fever and White Plague: Voluntary Sacrifice of Individual Liberty" looks at the conflict between the ideals of American liberty and individual freedoms as well as the obligation the government had to protect the citizens it served. Hayward, like all American communities in the early 1900s, suffered from frequent epidemics. It seemed that the best way to limit epidemics, in the absence of certain cures, was to curtail individual freedoms. By the end of the 1910s Hayward's doctors had discovered, as had boards of health in communities throughout the United States, that coercion was ineffective. More efficient in checking epidemics were efforts that relied on voluntarism, especially those efforts that relied on appeals to Americanism. The eventual outcome of these efforts was the association of voluntarism, Americanism, and health itself. Haywardites were beginning to become convinced that the government was the legitimate source for standards of health and health care. They learned that sickness was a consequence of failing to comply with those government standards, good health meant the absence of sickness, and, by extension, that the government was to some extent responsible for the maintenance of good health.

Chapter six, "Health and the Managed Environment" focuses on the associations Haywardites and the LCO Ojibwe made between their health and their environment. While early Sawyer County residents clearly understood their environment as a resource from which they could extract both cures and poisons, by the 1910s, they considered the environment and its effects as situations that could be controlled. Moreover, control of

the environment could lead to better health. This new understanding of the environment as malleable was clearly influenced by Progressive Era cooperation between science, education, and government.

Chapter seven, "A Citizen's Rights: Public Health at the Hayward Indian School" explores the application of the developing health care system within a population of young Ojibwe who had been taken from the LCO and from nearby reservations to be educated at a government Indian School built in Hayward. Administrators at the school had a clear vision of the healthcare catechism, including an expectation of the existence of professional practitioners, modern facilities, and up-to-date pharmaceuticals. Further, school officials anticipated that OIA resources would produce what that catechism required: professional doctors and nurses would be hired; up to date buildings, including a fully functional hospital, would be built; and, the hospital would be stocked with medicines that would be appropriately dispensed by the medical professionals. Government officials in the OIA also had a clear vision of the health care catechism, but the operation of the new system at the Indian School was problematic, in part because of notions of race but also, largely, because of failures in the system itself.

The disappointments resulting from operations at the Indian School were profound and have long-lasting implications. Health care standards remained unmet in a setting controlled by officials of the same government that was setting those standards, and sickness continued to exist even after compliance to health care standards improved. In constructing a catechism that relied on the success of, and access to, such well-defined tenets of faith – the educated practitioners, modern facilities, cutting-edge pharmaceuticals, and scientific research – health care reformers ensured failure. The

licensing of health care professionals creates standard of care responsibilities for the agency doing the licensing. The setting and enforcement of government criteria for facilities, pharmaceuticals, and scientific research implies reliability as well as liability. Americans who accepted the notion that the government ought to be the agency in charge of these activities also began to expect that those activities would create health, as defined by the absence of diseases that required practitioners, facilities, pharmaceuticals, and access. Reformers had set the bar too high. The young Ojibwe living at the school and their families who remained at the LCO learned a lesson that Haywardites themselves had not learned by the early 1920s: bureaucratic health care promises redemption but ensures no salvation.

CHAPTER ONE:
HOSPITALS AND HEALTH INSURANCE IN A BACKWOODS COMMUNITY

In the spring of 1895, the hometown newspaper in Hayward published a full, two-page article depicting the small city's growth and successes since its founding twelve years earlier. The paper's editor, J.H. Williams argued that when compared to the achievements of other small cities in northwestern Wisconsin, Hayward's success was solid, not "blown into bladder-like proportions by wind power" nor "brilliant but not altogether safe." Instead, Hayward was a community of "earnest, alert, [and] energetic" businessmen with solid foundations. It was a "clean, healthful, bright and active city and in all respects a good residence town" that would grow "quietly and steadily too, without a 'boom' without great speculative fevers or fluctuations in values."[1] In this description, Williams joined a national discussion regarding the disappearing American frontier; he maintained that Hayward was firmly established as a modern community made up of hard working Americans.[2] In effect, Williams was arguing that the term "frontier" no longer applied to Hayward. And, a line of frontier was not needed, for the city's population provided clear evidence that American individualism and the American work ethic did not depend on outside pressures for nourishment.

Williams continued, in this article that was clearly designed to attract new residents and promote Hayward's continued success, to explain just what it had that made

[1] *HR*, 7 March 1895.

[2] This national discussion about the frontier began in 1893, the same year that Hayward was founded, when historian Frederick Jackson Turner delivered a powerful paper at a meeting of the American Historical Association. See the discussion of the frontier and Turner's argument in the Introduction.

it a sturdy community. He described it as a regional marketplace that was supported by a "soundly established" core of manufacturing and a growing agricultural base. Multiple churches, schools, and societies – "musical, literary, [and] social" – served a population that had "no floating pauper elements" but instead was "hearty, hospitable and generous."[3] In addition, friendly and reliable town and county government officials served the people and businesses of Hayward and of the surrounding Sawyer County. In short, Williams made clear the requirements a community had to meet in order to no longer be part of a frontier; it had to have a mature economic climate, settled social structure, and firm political organization.

In spite of Williams' relentless boosterism, which persisted for the next five years, Hayward was a classic "frontier" town.[4] It had all the appearances of being a mature city, including fixed population levels and a well-established physical infrastructure, but far from being stable, Hayward was undeveloped. The city's political structure changed often and rapidly, and its legal system was applied haphazardly. Businesses typically started and failed in speedy succession, and the ones that endured relied heavily upon the extraction of lumber, a natural resource that was quickly becoming depleted. Further, while population levels remained stable, the population itself was incredibly fluid; the

[3] *HR.* 7 March 1895

[4] For my purposes, the frontier is a place where civilizations and ideas meet, society and social norms are continually being renegotiated, the government is unstable and its laws are unevenly applied, and the economy is often unsound. The word "frontier" does not necessarily require the existence of an unsettled piece of land; it can be applied to a small town, like Hayward, that had a volatile political structure and unpredictable legal system as well as a fluid social order, in which the most unlikely citizens could reign over a Gilded Age community. Richard White's work, *The Middle Ground*, provides the basis for my definition of a frontier. Although his work focuses on the intersection of European and Native American cultures between 1650 and 1815, I believe that the concept of "frontier" as "middle ground" can be widely applied and is appropriate for understanding the evolution of Gilded Age/Progressive Era northern Wisconsin.

city rarely was a final destination, instead remaining a temporary home for a mostly transient population. And, census figures show that Sawyer County, exclusive of the LCO, was a typical frontier population with a skewed gender ratio; a full 61% of the population was male.[5] These residents not only contributed to Hayward's frontier status; their culture thrived upon it.

Hayward's health care system epitomized the city's general instability. The leading citizens of Hayward and of Sawyer County declared that their community had all the advantages of a modern, American city, including efficient and functional health care. In reality, the locals had a tendency to look elsewhere when they fell ill. They bought patent medicines from distant vendors on the advice they found in newspapers or on recommendations of neighbors. If they required a doctor, they typically expected him to make a house call. If they needed specialized care and had the financial resources, they traveled over 100 miles to Eau Claire, Wisconsin or 125 miles to St. Paul, Minnesota. If they lacked the financial resources to travel, they sought "alternative" practitioners at the expense of the local doctors' businesses. Permanent residents repeatedly attempted to improve the community's health care system; they celebrated the employment of educated pharmacists in the local drug stores, and they campaigned for the establishment of a modern hospital. However, the city was too remote and rural to attract and keep most well trained practitioners, and the population was too unstable to support the development of a truly functional, accessible, and modern health care system.

[5]"Part I - Population," in *Compendium of the Eleventh Census: 1890* (Washington: Government Printing Office, 1892). Census figures show that the total population was 1,207. Of 1,142 native born citizens, 652 were male and 490 were female. Of the 835 foreign-born citizens, 555 were male and 280 were female. Statewide, the ratio was almost 52% male to 48% female.

In Wisconsin, the far northwest was the last area that could officially be defined as a "frontier." Settlement there was relatively slow, in no small part due to the geological processes that had taken place there over tens of thousands of years. Until about 10,000 years ago, glaciers periodically moved across Wisconsin, smoothing much of the northern area of the state into a dome. The high point of the dome is in the north-central part of the state, and rivers flow from that area either north towards Lake Superior, southwest towards the Mississippi River, or southeast towards Green Bay and Lake Michigan. Because the area was thickly wooded and almost always up-river, Northwestern Wisconsin, thus, was not easily approachable before the advent of the steam engine. Further, the rivers that reach into the area have steep gradients, requiring frequent portages through those thick woods.[6] (Fig. 1.1)

Until the late 1600s, low population levels in the area clearly reflected the region's inaccessibility.[7] As European settlement encroached on Algonquian territories in eastern North America, however, those tribes began moving west. Among the Algonquians who moved into northwestern Wisconsin were the Ojibwe, who were firmly settled in the area by the mid-1700s.[8] Like the Sioux who had lived there before and who

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[6] Mark Wyman, *The Wisconsin Frontier* (Bloomington: Indiana University Press, 1998), 21-32.

[7] Walker D. Wyman, with Kurt Leichtle, *The Chippewa: A History of the Great Lakes Woodland Tribe over Three Centuries* (River Falls: University of Wisconsin-River Falls Press, 1993), 25.

[8] The term "Algonquian" refers to multiple Native American tribes who speak languages that are related to each other – these languages are as diverse as European languages with common roots, such as German, Dutch, Norwegian, and English. The Ojibwe are one of the larger tribal groups with Algonquian origins; they are variously known as Ojibwa, Ojibwe, and Ojibway, along with multiple other anglicized spellings. Officially, the US government identifies the tribe as Chippewa, and some Ojibwe use the term Anishenabe when describing themselves. Anishenabe is a name that also self-identifies; as I am not Ojibwe, I do not use the term. The Lac Courte Oreilles tribe identifies itself to others as Ojibwe, so that is the spelling I have used throughout this dissertation except when I am quoting or citing another's work. The tribe uses the original spelling of Lac Courte Oreilles, although most modern sources have anglicized the name to Lac Court Oreilles.

had themselves been pushed west, the Wisconsin Ojibwe were semi-nomadic hunters, fishers, and gatherers. They hunted deer and small game year round, tapped maples in the spring to produce sugar, gathered blueberries in the summer, and harvested wild rice in the fall. They lived in domed lodges created by covering branch frames with bark, a semi-permanent type of construction that was well suited to the tribe's hunter-gatherer culture.[9]

At about the same time that the Ojibwe moved into northwestern Wisconsin, French fur traders also made their first forays into the area, and by 1700 the French crown had established the area as a colony. The French fur traders assimilated relatively easily into Ojibwe society. Mostly single males, the traders married into the tribes, making connections that benefited both the traders and the tribes. The traders' wives served as interpreters, guides, cooks, and companions, while the traders assisted the tribes as sources of income and conduits for the trade that brought manufactured goods into the area. Through that trade, the Ojibwe gained items that made everyday life much easier, including pots, fire-starting utensils, woven cloth, and manufactured tools with metal points. In addition, the fur traders brought alcohol, a liquid that was so valuable and desirable that it served both as an intoxicant and as a form of currency.[10] From the

[9] Wyman, *The Chippewa*, 34.

[10] The use of alcohol as a trade item continued well into the era of British administration, beginning in the mid-1760s. See: Robert E. Bieder, *Native American Communities in Wisconsin, 1600-1960: A Study of Tradition and Change* (Madison: University of Wisconsin Press, 1995), 97-8; and Wyman, *The Wisconsin Frontier*, 109-11.

Ojibwe perspective, the fur trade itself meshed nicely into tribal practices; it built on a culture of reciprocity that had developed among the Ojibwe for centuries.[11]

Closely following the French fur traders were Catholic missionaries. Contact between French Jesuit missionaries and the Ojibwe living in northwest Wisconsin has been dated to as early as the 1640s, but sustained contact did not occur until the mid-1660s. In 1665, Father Claude Jean Allouez built a "bark chapel and for himself a hut next to it" on the shores of Lake Superior east of what would later become Duluth. At this mission, Father Allouez earnestly began his duties, baptizing as many Native Americans as he could. His efforts were misinterpreted; family members of infants who had died after baptism suspected that the "sacrament [had] caused the infants' deaths."[12] Unsurprisingly, the mission was not successful, and by the early 1670s, it was abandoned. In 1835, a priest named Father Baraga traveled to the area and reestablished the mission at LaPointe on Madeline Island; eventually, the missionaries who worked the area moved their headquarters to Bayfield, on the mainland. In 1878, the mission at Bayfield was put in the charge of the Franciscans and operated by German and Dutch priests. By the early 1880s, the Franciscans had established a small church, under the supervision of the Bayfield mission, at Lac Courte Oreilles (LCO), the Ojibwe reservation that borders Hayward.[13]

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[11] Bieder, *Native American Communities in Wisconsin*; William W. Warren, *History of the Ojibway People* (St. Paul, MN: Minnesota Historical Society Press, 1984); and Wyman, *The Wisconsin Frontier*.

[12] Rev. Leo Rummel, O. Praem., *History of the Catholic Church in Wisconsin* (Madison: Knights of Columbus, 1976), 13.

[13] *Ibid*., 117-8; Harry H. Hemming, *The Catholic Church in Wisconsin: A History of the Catholic Church in Wisconsin from the Earliest Time to the Present Day* (Milwaukee: Catholic Historical Publishing Company, 1896), 772-8; and Father Chrysostom Verwyst, "Ideas and Experiences of a Missionary," *The Indian Sentinel* (1908).

While northern Wisconsin for these Native American and European migrants was a cultural frontier, an area in which their cultures met and the people negotiated new social norms, the region was also a disease frontier. The migrants brought European diseases with them, including measles, typhoid, scarlet fever, and, most significant, smallpox. Father Allouez had found evidence of an early smallpox epidemic among the Wisconsin Menominee in 1669, although he blamed depleted population levels on wars between the Menominee and the "refugee Algonquian."[14] Another wave of smallpox moved through that area in the 1680s, and local tribes "blamed the Jesuits, whom they believed had cursed them with the disease."[15] The Ojibwe in the northwest also experienced smallpox epidemics as well as measles, "the great red skin," and they were subject to the cholera epidemics of 1834 and 1837.[16] These diseases did not enter a pristine wilderness free of its own maladies; the low-lying wetland was famous for its mosquito population, which carried malaria. One traveler from New England, who visited an Ojibwe village at LCO in 1767, designated the area "mosquito country."[17]

After the United States acquired the area in 1783, American settlement surged westward, but northern Wisconsin remained remote. By the mid-1800s, the area was still only settled by the Ojibwe and the *métis* – children of the marriages between Ojibwe and the French fur traders. The region would remain relatively isolated until the population in other areas of the Old Northwest reached critical mass. Transportation in and out of

[14] Bieder, *Native American Communities in Wisconsin*, 59. The Menominee settled the eastern part of Wisconsin, near Green Bay.

[15] *Ibid*., 61.

[16] *Ibid*., 148.

[17] Wyman, *The Chippewa*, 91.

the area remained difficult, a situation that would not change significantly until the arrival of the railroads. Finally, the area was clearly unable to support large-scale agriculture, a condition that was often necessary before sizeable immigration to the American Midwest would occur.[18]

Until that immigration occurred, the residents of Northern Wisconsin thrived in the economy that had Ojibwe and French foundations. This "*métis*" economy was based both on traditional hunting and gathering and on the European fur extraction. In the first decade of the 1800s, the American Fur Company began working in the area, entering in competition with the Hudson Bay Company, which had been operating in the region for only a short time.[19] As one of its principal traders in the area, in 1800 American Fur employed Jean Baptiste Corbin, a well-established trader who had originally worked for the competition. As an employee of American Fur, he established a trading post at the small Ojibwe settlement at LCO. Like other French fur traders, Corbin married into the tribe he lived with, and he raised a large family of *métis* children who had their feet firmly planted in both traditional Ojibwe and French cultures. Enough of Corbin's children remained at LCO to make the name common in the area a full century later.[20]

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[18] For more on immigration, see: Kathleen Neils Conzen, *Immigrant Milwaukee 1836-1860: Accommodation and Community in a Frontier City* (Cambridge: Harvard University Press, 1976); William Cronon, *Nature's Metropolis: Chicago and the Great West* (New York: W.W. Norton & Company, Inc., 1991); Jon Gjerde, *From Peasants to Farmers: The Migration from Balestrand, Norway, to the Upper Middle West* (Cambridge: Cambridge University Press, 1985); ———, *The Minds of the West: Ethnocultural Evolution in the Rural Middle West, 1830-1917* (Chapel Hill: The University of North Carolina Press, 1997); and John Higham, *Strangers in the Land: Patterns of American Nativism, 1860-1925*, 2nd ed. (New Brunswick, NJ: 1988).

[19] The Northwest Fur Company, which was established in 1787, operated in Great Lakes region and eventually merged with the Hudson Bay Company in 1819.

[20] Shelley Oxley, *The Anishinabe: A Unit on the History of the Lac Courte Oreilles Band of Lake Superior Ojibway Indians* (Madison, WI: Wisconsin Department of Public Instruction, 1981), 6. Some Corbin descendents spelled the name with an e – Corbine.

Another migrant who came to the area early and stayed permanently was Louis Demarie, "a Canadian Frenchman from Montreal, with his wife, a French and Ojibwe" woman who had "uncommon natural abilities and with education and culture" that clearly marked her as part of a successful *métis* community. She was also an essential part of that community, as other residents recognized her as "a born physician and for many years the only one in the valley."[21]

While northwestern Wisconsin remained remote enough to facilitate the continuation of a *métis* economy, the rest of the state, fed by both the region's natural resources and large-scale immigration, developed rapidly into a vital piece of the growing American industrial economy. The largest city in the region, Chicago, had been only a small settlement as late as the 1830s, but by the 1860s, it had become the fourth largest city in the United States and a major agricultural distribution point, due in large part to the growth and expansion of the railroad. As that city grew, other natural ports in the vicinity supported the growth of sister cities, such as Milwaukee. By 1836, Wisconsin had acquired a population large enough to support territorial organization. The population continued to grow exponentially, and only twelve years later it was large enough to form a state. That same year, 1848, was the year of mini-revolutions throughout Europe, revolutions that sent waves of central European migrants to the United States and many of those to Wisconsin. The population growth and rising crop prices throughout the world, along with the rapidly expanding railroad network connecting southern Wisconsin with Chicago, facilitated an agricultural economy in that

[21] *Bartlett, William W., Lumbering in the Chippewa Valley, WI, in Pioneer Times, 1930*, 18. Bartlett does not date the Demarie migration, although it likely occurred in the 1830s.

part of that state. At the same time, port cities along Lake Michigan developed into industrial areas that particularly focused on manufacturing agricultural implements. Finally, the southwestern area of the state developed into a magnet for mining companies; discoveries of large lead deposits led to a "lead rush" in the 1820s and enticed tens of thousands of immigrants into that region.[22]

Northwestern Wisconsin, like the southern part of the state, clearly had its own reserve of natural resources that would eventually attract significant settlement. The climate and landscape had made possible the growth of vast white pine forests. As the fur trade declined with the near extinction of the beaver and other fur producing animals, the fur traders, both of European and Ojibwe ancestry, began to engage in lumbering. These new loggers, however, were restricted in their activities by the geography created by the ancient glaciers. While there was an abundance of pine that could be cut, it was exceedingly difficult to pull the cut logs from the woods and send them to lumber mills in more industrial areas. Logging was limited to areas that were served by fast-flowing rivers, a condition that only changed with the development of railroad technology.[23]

Before large-scale resource extraction and permanent settlement could occur, a critical issue had to be resolved. Simply put, the region was not an empty wilderness that could be claimed by logging companies or land speculators. In 1854, the US government, by treaty with the Ojibwe, had allotted reservation lands in Michigan, Minnesota, and Wisconsin. In northern Wisconsin, these lands included: Bad River at

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[22] Wyman, *The Wisconsin Frontier*, 137-40.

[23] William Bartlett, "C.H. Cooke Diary," in *Bartlett Papers*; Robert F. Fries, *Empire in Pine: The Story of Lumbering in Wisconsin 1830-1900* (Madison: The State Historical Society of Wisconsin, 1951); and Ralph Hidy, Frank Ernest Hill, and Allan Nevins, *Timber and Men: The Weyerhaeuser Story* (New York: The Macmillan Company, 1963).

Odanah, about thirty miles from Bayfield; Lac du Flambeau, in the north-central part of the state; Red Cliff, only three miles from Bayfield; Mole Lake, in the north-east part of the state; and LCO, about 85 miles southwest of Bayfield and on the Namakagon River. As the reservation boundaries became established and accepted, at least nominally, by the local residents, the surrounding lands could be claimed.[24]

And claimed they were. In the upper Chippewa valley, multiple logging and lumber companies soon began operations.[25] In 1881, the first sawmill in what would later become Sawyer County was built at a new settlement called Hayward. Called the North Wisconsin Lumber Company (NWLC) and owned by Frederick Weyerhaeuser, the mill employed about 300 men and operated for a little more than six months out of the year. The enterprise was a modern one, run by steam, lit by electricity, and serviced by automatic fire sprinklers.[26] During the winter, most of the sawmill's employees logged the woods for one of the numerous logging companies, and in the summer they returned to their positions at the mill, cutting and shaping the logs into saleable lumber. By the winter of 1889-1890, the mill was producing about 30 million board feet every year, an output that increased as technological improvements were made. By 1893, the mill "held the world's record for cutting with two band saws and two gang saws."[27] In 1896, average yearly output had risen to 38 million board feet.[28]

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[24] *Treaty with the Chippewa, 1854.*

[25] Introduction, "C.H. Cooke Diary," *Bartlett Papers.*

[26] *HR,* 26 November 1896; 24 June 1897.

[27] *Sawyer County Agriculture* (Madison, WI: Wisconsin State Department of Agriculture, 1955), 4.

[28] *HR,* 26 November 1896.

The phenomenal early growth of the logging and lumber companies in the area fueled European immigration and the establishment of a permanent settlement. Norwegian and Swedish immigrants, in particular, flooded into the area. By 1883, only two years after the NWLC had been established, the area was developed enough for the state to create a new county, Sawyer, named after prominent logger and Wisconsin Senator Philetus Sawyer. And, the village of Hayward had a large enough population to become the county seat, although males still represented a majority of that population.

It was just twelve years later that editor Williams lauded Hayward for not being a "boom town" but instead for having a "solid backing" – industrial, agricultural, and commercial – for all of the area's 2000 white residents. The editor claimed that the city had an "earnest, alert, energetic liberal lot of business men, who [were] doing business on their own capital and not on borrowed money." He further argued that there were no "shaky" merchants in the city and that there was "no destitution among her people" but that there were available jobs for all. In addition, he declared that the city was "clean, healthful, bright and active" as well as a "good residence," features that clearly rested on the existence of schools, churches, and musical and literary societies. The future would be bright and full of "healthy growth" – clearly defined as steady rather than explosive.[29]

Among the businesses that established this level of "healthy growth" were the NWLC, the Chicago, St. Paul, Minneapolis & Omaha railroad that served the NWLC, and the NWLC company store. The Sawyer County Bank – the only bank in the area – was co-owned by the NWLC's owner, Frederick Weyerhaeuser, and its manager, R.L. McCormick. The businesses in Hayward that were not owned by the NWLC served the

[29] *HR*, 7 March 1895.

population that worked at the NWLC. Among those were three general stores, two groceries, three millinery shops, five hotels, a hospital, and a pharmacy. Altogether, the businesses served the city's 2,000 residents, a population level that remained nearly stable for the next decade.[30] (Figs. 1.2-1.13)

Culturally, it seemed that Hayward was also a typical mature and modern American city by the mid-1890s. The free library had been founded in 1887, and by 1896 had about 2000 books, 600 patrons, and over 6,700 checkouts per year. In addition, the library carried subscriptions to 14 papers and 9 magazines in its reading room and served as a reference point for the students at the high school.[31] The school system was also clearly established, with over 290 students enrolled in grades from kindergarten to high school.[32] In addition, Hayward claimed five churches, one of which held services every week; the other churches held services during their ministers' regular scheduled visits. The city's two pool halls and fifteen saloons, including the one run by the county sheriff, were presumably open every night.

Supporting the image of Hayward's stability was the city's physical infrastructure. Hayward's downtown buildings were electrified by the NWLC in 1888, and the town was "supplied with Namakagon [River] water through a very complete system of water works," an improvement that had been approved by the voters in the city in 1887. By 1890, "most hotels and businesses" in the city had tapped into the water

[30] *HR*, 26 November 1896.

[31] *HR*, 7 March 1895; and Adams, *History of Education*, 177.

[32] *HR*, 10 May 1894.

works.[33] The main street was paved in 1896, and more of the city's streets were paved every summer.[34] Residents had built a cemetery in 1882, even before the city was officially established; the area's rapid growth rate made it necessary for Haywardites to move the cemetery from what became the main residential area to a location further away.[35] The fire department was a volunteer company, but the county had a paid sheriff and a deputy, and Hayward had two, and sometimes three, paid policemen. The county government was run by a board, whose membership was, incidentally, the same as Hayward's supervisory board.

Overall, then, Editor Williams' assertion that Hayward was not a frontier "boom town" appeared to have been correct. Even though the area had developed rapidly, the population level was stable, and the city's infrastructure and culture seemed to be mature. Moreover, the local business community appeared to be thriving. Cracks in this façade, however, made it clear that Hayward was indeed a middle ground, a frontier where ideas and civilizations were meeting, where social norms were being renegotiated, and where the economy was incredibly unstable. The most visible crack in the façade was that of the political and legal system. Hayward was still a place of contested visions regarding who was part of the community, who should be in charge, and what relationship that community should have with the state and federal governments.

At some points, the cracks in the political and legal system were only hairline fractures, revealing that the folks in this social and economic borderland had, at the very

[33] Eldon Marple, *Visitor*, 18 September 1971; 11 August 1984; and *HR*, 26 November 1896.

[34] *Visitor*, 11 August 1984.

[35] *Visitor*, 22 May 1987. Coincidently, the cemetery moved away from the city's water supply; the move likely – and unintentionally – helped Haywardites delay their final change of residence.

least, an incomplete understanding of federalism at the state level. Wisconsin state law, in effect before Hayward was even established, required that organized communities create local boards of health. Those boards of health were then required to communicate with the SBOH and cooperate with its dictates, including those that compelled the reporting of vital statistics.[36] Hayward established a board of health, conveniently making its composition the same as the town board, as well as that of the county board of supervisors. And, the city appointed a health officer, complying with the SBOH request that the health officer be a trained physician. The city, however, appeared to have a more casual attitude than the state regarding the purpose of a local board of health. Dr. Trowbridge, Hayward's chosen health officer, reported to the state in 1889 that while "the Health Board organized promptly," it "holds no regular meetings apart from those of the town board, from which, however, its members are taken."[37]

Reporting of vital statistics to the state was sporadic, at best. The state received no report from Hayward or Sawyer County for 1885, 1891, 1893, or 1897.[38] Although local records unmistakably show that there were at least 31 deaths between January 1903 and April 1904, including a cluster of deaths from diphtheria and related illnesses, none of these deaths was reported to the SBOH. The mortality cluster indicated the existence of a minor epidemic, a situation that required mandatory reporting, but no epidemic was reported.[39]

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[36] 10th *SBOHR*, 4, 21.

[37] 12th *SBOHR*, 288.

[38] 9th, 14th, 15th, and 17th *SBOHRs.*

[39] "Pre 1907 Wisconsin Deaths: Sawyer County," WHS.

The deficiency in reporting appears to have been trivial to Haywardites, and Hayward was certainly not the only city in the state that was not meticulous in its reports. It is certainly possible that the deficiency was a consequence of the health officer's demanding position as one of only a few physicians in a large territory. More likely, it was a consequence of the local Board of Health's casual attitude towards seemingly "unimportant" legislation as well as a lack of understanding regarding the State Board's authority.

Even on the local level, the law regarding reporting was followed only sporadically. In 1901, Trowbridge claimed that "the law requiring the report of births is fairly well observed," but only two years later, he admitted that the law was "not fully observed."[40] Local records plainly show that the deficiency in reporting was not due to midwife- or family-assisted births; Hayward's doctors often filled in "missed" reports with the county clerk at the end of the year. This habit of reporting births months after the fact was mirrored in the reports of deaths, which at times were reported to the clerk nearly a year late.[41] Even the law requiring burial permits, Trowbridge reported, was only "usually" observed.[42] The state was aware of this problem, which was not confined to Hayward or to the northwestern and rural parts of Wisconsin. In 1905, the SBOH admitted that "the section of the law requiring the use of birth certificates is violated in every section of the state by both physicians and midwives." The board estimated that

[40] 18th *SBOHR*, 260; 19th *SBOHR*, 270-1.

[41] "Pre-1907 Wisconsin Births: Sawyer County," WHS; and "Pre-1907 Wisconsin Deaths: Sawyer County," WHS.

[42] 19th *SBOHR*, 270-1.

only a quarter to a third of all births statewide were reported correctly.[43] The problem in Hayward, however, was chronic, continuing well into the city's third decade and long after cities in the southern part of the state had regularized their reporting. Hayward was cited as late as 1917 and 1918 for not reporting vital statistics.[44]

Problems with underreporting to other state agencies underline the fact that local officials were not only casual about health legislation; in general, they were indifferent about state legislation regarding statistical information and directives regarding standardization. For example, the state required reporting of vital statistics regarding education. Local officials were proud of the Sawyer County school system; news editor Williams' "booster" reporting continually lauded the local schools. And in 1902, the local superintendent, J.G. Adams, published a booklet describing Sawyer County's schools, its course of study, and its distinguished graduates; this booklet also describes the beginnings of a local PTA during the 1898-1899 school year.[45] Clearly, the community was involved in and supported the school's mission to educate local children. Yet, the state superintendent's biennial reports show that the Sawyer County superintendent of schools did not fully report local statistics to the state. The first complete report to the state was made in 1896, a full 13 years after Hayward – and its school system – had been established.[46] This deficiency in reporting cannot be explained by claiming that the local superintendent had a demanding position that allowed little

[43] 20th *SBOHR*, 130.

[44] 27th *SBOHR*.

[45] Adams, *History of Education*.

[46] *Biennial Report of the State Superintendent of the State of Wisconsin for the Two Years Ending June 30, 1896*, ed. State Superintendent of Schools (Madison, WI: Democrat Printing Co., State Printers, 1896), 70.

time to create reports; reports of attendance were published regularly in the local newspaper. More likely, as in the case of vital statistics, the local officials saw no need to report to the state. Their vision of the state's authority was very different from the state's vision of its own role in local affairs.

One area in which the local authorities saw a clear role for the state was in enforcing law and order, especially in conflicts between the local authorities themselves. In spring, 1901, a new newspaper set up shop in Hayward. The editor and publisher of the *Hayward Enterprise* (hereafter *Enterprise*), William E. Schei, with the support of the NWLC and NWLC manager and Sawyer County Bank co-owner R.L. McCormick, soon began publishing inflammatory articles accusing local city and county officials of corruption and graft. Editor Schei focused his muckraking journalism on county officials who would be up for election later in the year, especially the county sheriff, William Giblin, and the county clerk, Otto Christianson. The officials that Schei had targeted – with the support of McCormick and the NWLC – apparently "had not always been considerate" of the NWLC's interests. Schei accused Sheriff Giblin of dereliction of duty and of allowing some of his prisoners to wander about town during their incarceration. Otto Christianson was accused of selling hunting licenses and pocketing the fees. And the county officials, overall, were accused of manipulating the votes of the Ojibwe living on the LCO. Schei argued that although the Ojibwe "should have no right to vote since they pay no taxes," they were accompanied to the polls by supporters of the reigning county officials and then were directed regarding how they should cast their votes.[47]

[47] *Visitor*, 24 May 1975.

Tensions escalated when Christianson responded to Schei's accusations by suing him for $10,000 and having him arrested. When Schei was released on bail, he promptly published an account of his experiences, describing the jail as "filthy beyond the habitation of man and corners where dirt had gathered, so thick were the maggots that a slip of paper thrown … would almost be bourne away on their backs."[48] Not surprisingly, Sheriff Giblin confronted Schei regarding this latest allegation; Schei responded by pulling a gun on the sheriff, and he ended up back in jail.[49] Within weeks, Schei began personally suing many of the locals who supported the incumbents, including a city policeman, the administrator at the LCO reservation, and the son of *Republican* Editor J.H. Williams; by law, Sheriff Giblin had to jail all of the targets of these lawsuits.[50]

Despite the *Republican* editor's insistence that Schei and the new newspaper were backed by the NWLC, which was the "enemy of the taxpayer and the laboring man," the muckraking, half-truths, and provocation had their intended effect. The election on April 1, 1902 was chaotic, and charges of fraud multiplied. Some citizens reportedly voted several times in order to "get an extra share of the purported $15,000 kitty put up by the challengers," and a "large group of Indians were kept overnight in a barn" and then brought to vote after they had each received $10 bribes.[51] At 2:10 that afternoon, Sheriff Giblin sent a terse telegram to Wisconsin Governor Robert LaFollette requesting the state

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[48] *Ibid.*

[49] *Hayward Enterprise* [hereafter *HE*], 19 February 1902.

[50] *HE*, 19, 26 March 1902.

[51] *Visitor*, 24 May 1975.

militia: "Riot threatened, threat made that Mill employees and others are to be called out to force possession of offices open revolt against my effort to maintain order." By the end of the day, anti-incumbent candidates claimed victory, but the incumbents refused to relinquish the keys to city and county offices.[52]

Unfortunately for the incumbents, the NWLC and R.L. McCormick had the ear of the governor. McCormick's son, who happened to be in Madison, gave early reports of the conflict to the governor; these reports stated that there was no trouble and that Sheriff Giblin was fabricating the extent of the conflict. The governor, nonetheless, sent the adjutant general of the Wisconsin National Guard to investigate the situation personally. R.L. McCormick and the newly elected city chairman met the adjutant general at the train station to ensure they got their story across first; by the time the men arrived at the city and county offices, McCormick had been able to persuade the adjutant general that the situation was truly under control.[53] Although the results of the election were supported in the court, they were overturned in the next election.

In this uncertain political climate and with an immigrant population that often left town sometimes only months after arriving, businesses started and failed in rapid succession. One of these transitory businesses was the local hospital, which was continually rumored to be "opening soon" when it was not open yet and was persistently rumored to be "closing soon" when it was open.[54] Sanborn fire insurance maps from

[52] Wisconsin, Governor, "Strikes and Riots, 1858-1909," Folder 3, WHS.

[53] Account from Chas. Boardman, Adjutant General, Wisconsin National Guard. 4 April, 1902, in Wisconsin, Governor, "Strikes and Riots, 1858-1909," Folder 3, WHS.

[54] While hospitals are treated, by patients, as institutions of compassion and charity, they are nearly always treated, by owners or boards of governors, as businesses that must make a profit in order to remain open.

1885 indicate that Dr. Cox, one of the local practicing physicians, had opened a hospital on the corner of Iowa and 1st street, in the middle of downtown Hayward. By April 1887, the hospital had clearly closed, as a new one was rumored to be opening soon. For this new venture, Dr. Cox and three local businessmen had "associated themselves together for the erection of a fine hospital building in Hayward," a project "which no one has heretofore taken hold of practically." The proposed hospital would be on Hayward's main street, Iowa, at the corner of 4th; the location was central, as the building would be across 4th from the Congregational church and across Iowa from the county courthouse and jail. The plan was to build a brick "Good Samaritan Hospital" two stories tall with a basement by the fall of 1888.[55] Within two weeks of these first reports, the hospital board decided instead to buy a building on Iowa and 1st that had been used as a hotel. While the purchase allowed the hospital to open a full year sooner than planned, the hotel manager and his establishment were evicted from the premises in the course of the transaction, a move that caused him to "feel greatly disappointed and aggrieved."[56]

The Good Samaritan Hospital board projected that business would be good, and not without reason. Within a week of the building purchase, locals had bought $400 in hospital tickets.[57] Before standardized health insurance, either hospitalization was paid for after the fact, or it was sold ahead of time by ticket. A ticket holder would pay a set amount, usually only a few dollars, with a yearlong guarantee of hospital care for serious illnesses and injuries. Early ticket systems limited buyers to certain hospitals; as the

[55] *North Wisconsin News* [hereafter *NWN*], 16 April 1887.

[56] *NWN*, 30 April 1887.

[57] *NWN*, 7 May 1887.

format developed, hospitals entered into agreements with each other, thus allowing ticket holders to have some level of hospital choice. [58]

With business looking good, the Good Samaritan Hospital Association invested in physical improvements and expanded its staff. The company installed a windmill, which powered a water pump, and it "made a large basement room for the steam heating apparatus." This steam heater and the water pump made possible the introduction of various types of baths, including "Turkish, medicated, and electric." In addition, the association built a veranda "across the whole south front" of the building and roofed it.[59] A new physician, who was said to have graduated from the Philadelphia University of Medicine and Surgery in 1865 and who claimed to be the "leading physician of the Buffalo Health Institute," was hired to assist Dr. Cox in his hospital duties.[60]

Within six months of the hospital's opening, however, the business was floundering. The new physician had not stayed, and Dr. Cox sold his interest in the association to another doctor in January 1888.[61] This doctor also only stayed a few months; by July, the physicians associated with the hospital were Cox, J.W. Wells, who stayed in town for only a few months after the hospital closed, and J.B. Trowbridge, who lived in Hayward until his death, many years later. While the hospital was struggling

[58] For more on the development of the American health insurance system, see: Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* (Princeton: Princeton University Press, 2003); Beatrix R. Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill: University of North Carolina Press, 2001); Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton: Princeton University Press, 2003); Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance 1912-1920* (Baltimore: Johns Hopkins University Press, 1978).

[59] *NWN*, 25 June; 2 July 1887.

[60] *NWN*, 25 June 1887.

[61] *NWN*, 21 January 1888.

with its staffing, the baths were opened to paying non-patients, as this would clearly increase the business's income. A bath, whether hot or cold, or a shower could be had for 35 cents, or a ticket for 26 baths could be bought for $5. A family bath ticket would cost $15. Specialty baths, including Turkish, Russian, electric, vapor, and medicated cost between $1 and $1.50 each. By September, the hospital announced that it would serve holders of Lumbermen's and Mechanic's Benefit Association tickets; clearly, the hospital was eager for patients whose care would be paid for by "a solid institution having a capital of $30,000."[62] By the end of the year, the Good Samaritan Hospital had closed its doors.

Only five years after Good Samaritan had closed its doors, Dr. Cox again tried his hand at the hospital business, this time with little more success. Cox leased another former hotel building in downtown Hayward in July 1894 and quickly began improvements to the building's infrastructure. In September, Cox bought several electrollers and a new "heating apparatus for supplying the different baths." And, he began selling hospital tickets to the mill and lumber company employees. Cox claimed to be doing well at the hospital business this time; in June 1895, he claimed to have served 1,317 patients just since November 1, 1894, and there had not been a single death at the hospital during that entire period. *Republican* Editor Williams pointed out that "the records of the State Board of Control at Madison show this to be the best death record of any institution in the state of Wisconsin. Whether or not there had been any deaths at the hospital, the number of patients Cox claimed to have seen is astounding. Cox would have had to see more than six new patients at his hospital every day for that seven-month

[62] *NWN*, 24 July; 8 September; 16 June; 22 September 1888.

period, in addition to serving the patients who could not travel to Hayward or who had not bought a hospital ticket. The level of Cox's exaggeration became clear in October, when he "discovered that it was not a paying investment, and so … arranged to close the business."[63] The building would be converted back into a rooming house.

The transitory nature of the hospital business in Hayward continued through to the end of the 1910s. A hospital – the first that was not associated with Dr. Cox – opened in 1904, but it closed within months. Again in 1912, the local papers reported more hospital rumors. Simply put, the local population was not large enough to sustain a business that required modern technologies and the dedication of doctors, who themselves were transitory. When given a choice, Haywardites took their medical treatments elsewhere, in large city hospitals that had the resources to buy modern equipment and to hire respected staff physicians. When the large city hospitals were not a viable option, Haywardites relied upon what 21st century Americans would call "alternative medicine." This reliance upon alternative therapies in conjunction with licensed medical care furthered the development of a transitory medical system, the subject of chapter two.

Overall, the instability in Hayward's health care system reflected the community's status as a frontier town, even long after the area had officially lost its designation as a frontier. Haywardites reveled in their political disorder and disregarded the more modern, statistical functions of the American state. Their best interactions with the state occurred in the context of a traditional definition of government: government exists to protect the people from harm. As we shall see, however, Haywardites were less

[63] *HR*, 26 July; 6 September 1894; 13 September; 20 June; 24 October 1895.

than willing to include risky health care practices in the category of situations that required government protection.

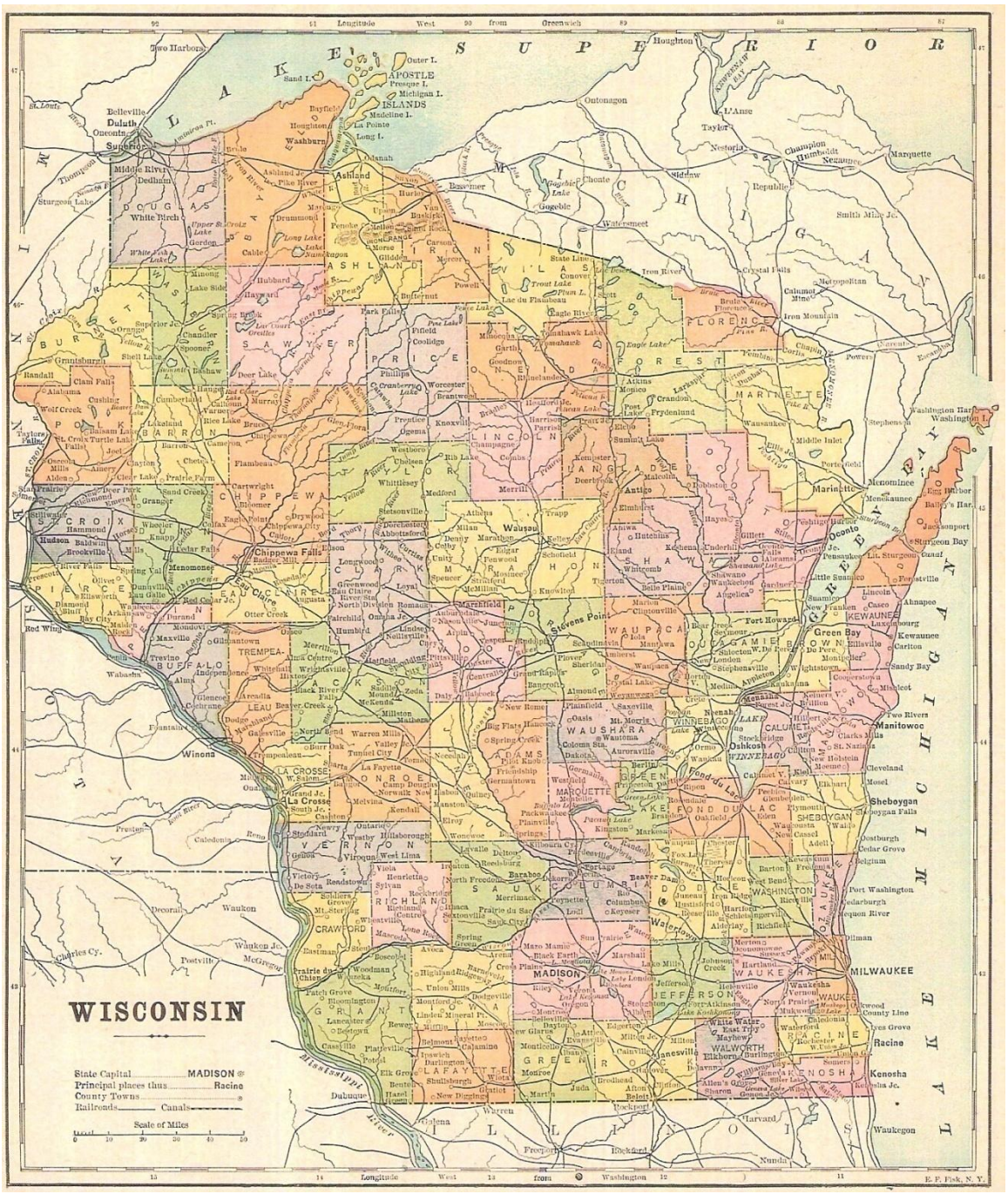

Fig. 1.1
Map of Wisconsin showing railroad lines – Sawyer County is in the upper northwestern corner of the state. Hayward, the county seat, is just north of Lac Court Oreilles.[64]

[64] W.H. DePuy, "Wisconsin," *The People's Cyclopedia of Universal Knowledge, Including a Complete and Indexed Atlas of the Globe* (New York: Hunt & Eaton, 1895).

Fig. 1.2
View of Hayward looking northwest up Iowa St. from the corner of Iowa and 1st. Various hotels usually occupied the two-story building on the left, but the building was converted into a hospital in April 1887. The Good Samaritan Hospital closed in September 1888, and the building was again turned into a hotel. The building directly across the street from the hotel is the Carnegie Library. The steeple in the background on the left side of the street belongs to the Congregational church.[65]

[65] "Main St., Hayward, Wis.," (The H. Montgomery Co., Post Cards: Minneapolis), n.d. Postcard from author's collection. Information regarding Hayward's street design and building locations derived from "Fire insurance maps from the Sanborn Map Company archives: late 19th century to 1990, Wisconsin," University Publications of America (Bethesda, MD), 1993 held in "Research collections in urban history and urban studies," WHS Library.

Fig. 1.3
Sawyer County courthouse at 4th and Iowa St., across the street from the Congregational church. The building to the left is the county jail.[66]

[66] "Court House, Hayward, Wisc.," (Bloom Bros., Importers: Minneapolis) n.d. Postcard from author's collection.

Fig 1.4
The county jail and the county courthouse occupied an entire block. The buildings were surrounded by cleared lawn and a few planted shade trees.[67]

[67] "Sawyer County Jail, Hayward, Wis." (Bradford & Co.: St. Joseph, MI) n.d. Postmark is 9/20/1910. Postcard from author's collection.

Fig 1.5
The high school was on 4th St, two blocks southwest of the courthouse block. It also occupied an entire block.[68]

[68] "Greetings from Hayward, Wis.," (H. Tomkins: Hayward, WI) n.d. Postcard from author's collection.

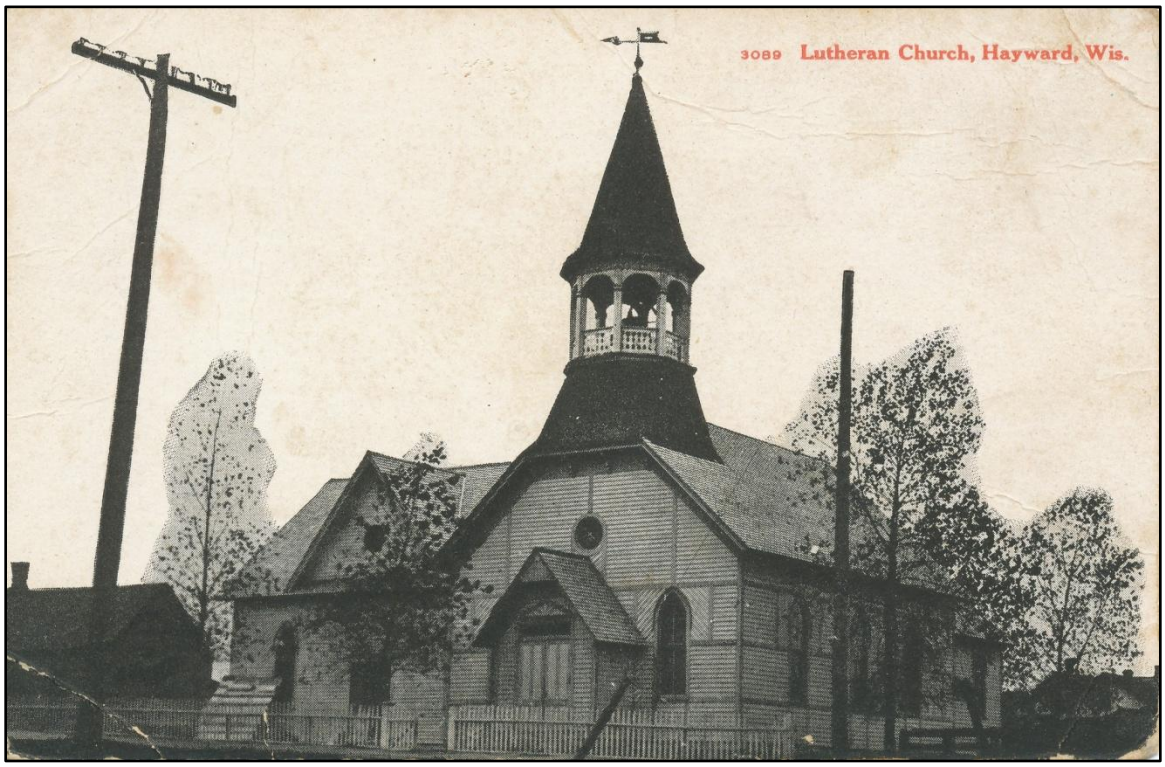

Fig 1.6
Hayward's churches were all on or near 4th St. The Congregational church was directly across the street from the courthouse, and the Catholic church was on the opposite end of the same block. The Methodist church was two blocks further down the street, across from the high school and on Minnesota. The Lutheran church was on the next block, at 4th and Michigan, while the North Wisconsin Lumber Company occupied the following block, at 4th and Florida.[69]

[69] "Lutheran Church, Hayward, Wis." n.d. Postcard from author's collection.

Fig. 1.7
Hayward's Catholic Church
Postmark is 1913[70]

[70] "Catholic Church and School, Hayward, Wis." n.d. Postcard from author's collection.

Fig. 1.8
The train depot was directly southeast of the Carnegie Library.[71]

[71] "Omaha Depot, Hayward, Wis." (E.C. Kropf Co.: Milwaukee) n.d. Postmark is 7/9/1908. Postcard from author's collection.

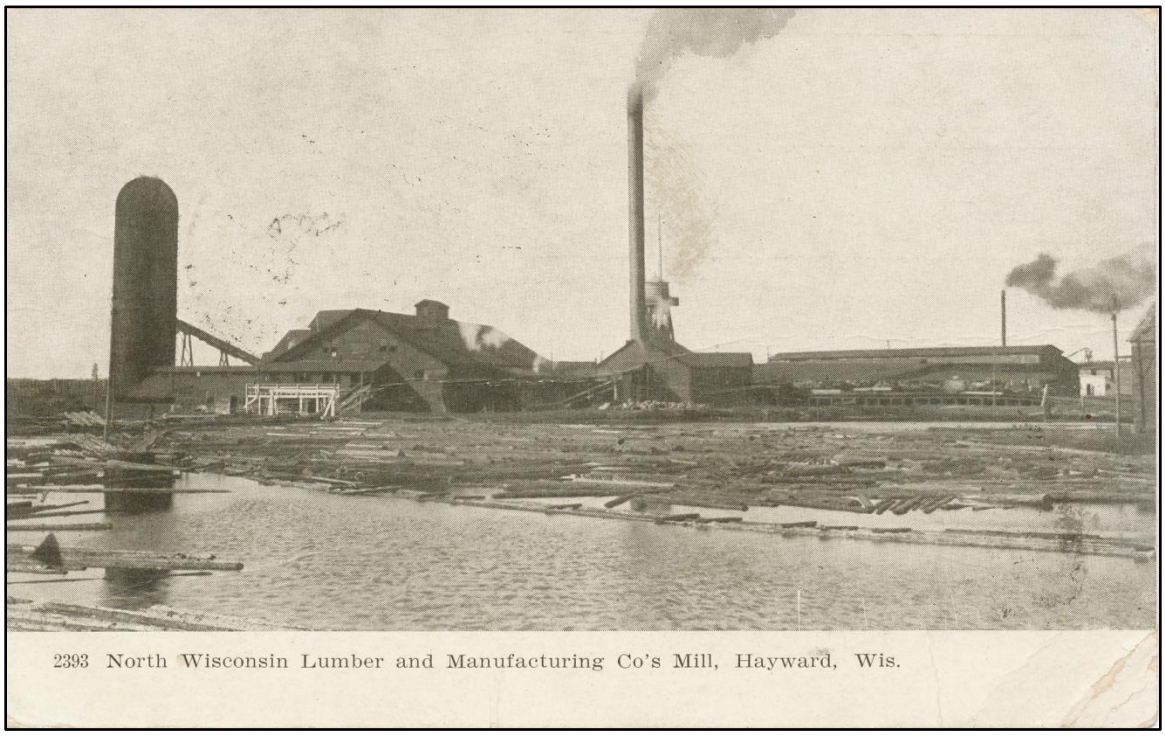

Fig. 1.9
The NWLC mill was about ¾ mile southeast of the city and was situated on the Namakagon River. The mill dammed the river at Bradley Brook, the small waterway that served as Hayward's open sewer.[72]

[72] "North Wisconsin Lumber and Manufacturing Co's Mill, Hayward, Wis.," (Minneapolis) n.d. Postmark is 1908. Postcard from author's collection.

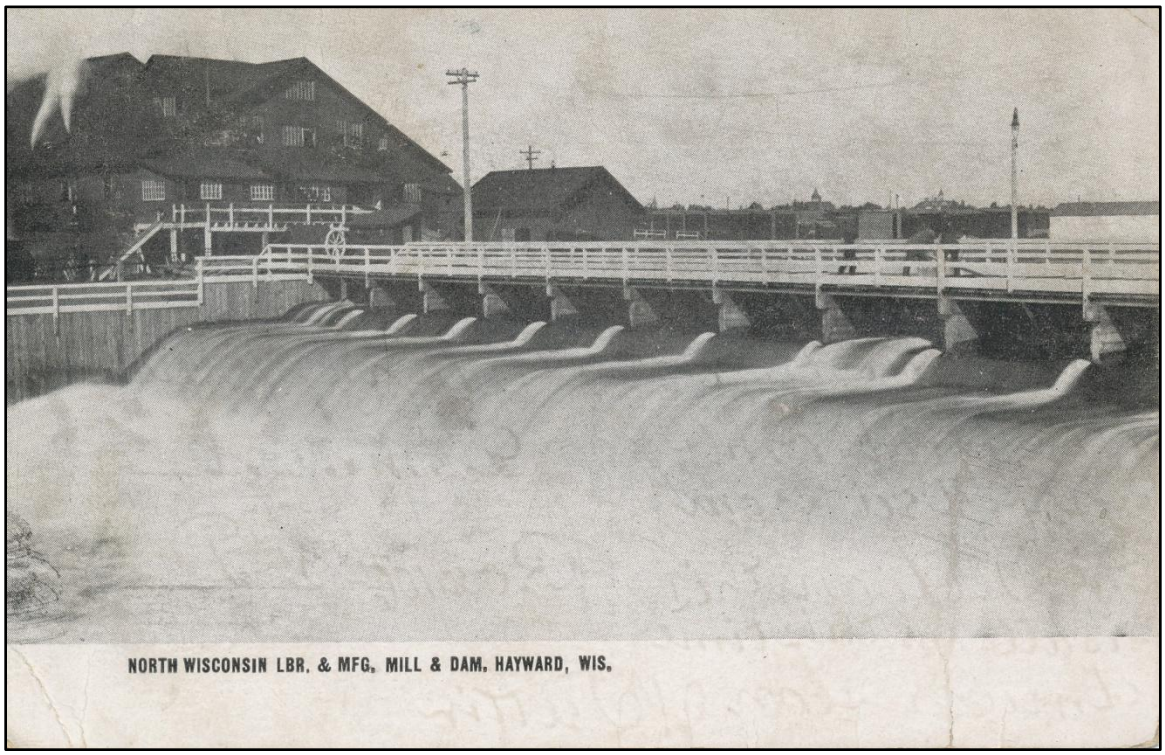

Fig. 1.10
Several of Hayward's church steeples and the courthouse tower are visible in the distance behind the NWLC mill and dam.[73]

[73] "North Wisconsin Lbr. & Mfg. Mill & Dam, Hayward, Wis." (Suhling Co.: Chicago) n.d. Postmark is 1908. Postcard from author's collection.

Fig. 1.11
Logs in the woods on their way to the river.[74]

[74] "Load of Logs, Hayward, Wis.," (Kropp Co.: Milwaukee) n.d. Postcard from author's collection.

Fig. 1.12
Logs on their way from the woods to the lumber mill.[75]

[75] "Driving Logs on Namakagon River, Hayward, Wis." (Trowbridge & Tompkins: Hayward, WI) n.d. Postcard from author's collection.

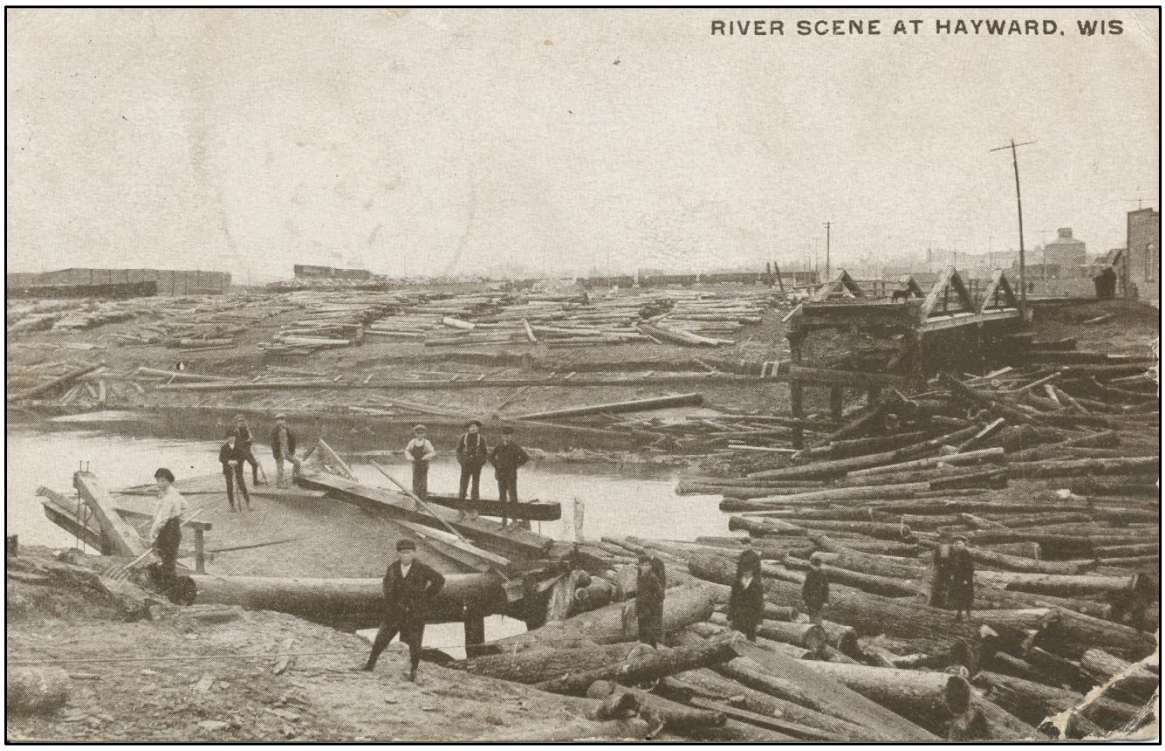

Fig. 1.13
The lumber mill is to the right. The train in the background transported finished lumber to markets.[76]

[76] "River Scene at Hayward, Wis." n.d. Postmark is 9/18/1908. Postcard from author's collection.

CHAPTER TWO:
FRONTIER MEDICS:
THE COUNTRY DOCTOR, THE MODERN PHYSICIAN, AND FOLK HEALERS

In early November 1887, the *North Wisconsin News* printed a shocking accusation against Dr. Joseph P. Cox, one that surely had been the subject of gossip in the area. A journalist from Eau Claire had written an article declaring that the doctor was a bigamist. Cox, according to the accusation, had been married multiple times. Two of the doctor's wives had died, but three were still alive: one in Hayward, one in Eau Claire, and the final one, Mary Cox, in St. Paul, MN. The father of the Eau Claire wife brought Mary to Hayward in the spring of 1887, where she "commenced proceedings against Cox in Justice court for bigamy." The night before the hearing, however, all the witnesses left town; they had heard that "a warrant had been issued for them."[1] At the hearing, the doctor could have asked for a dismissal, as there were no witnesses present. However, he declined this option, and the case was held over for trial. When interviewed about the case, Dr. Cox asserted that he was not guilty of the charge, and, further, the charge was a clear attempt to hurt his business. In short, Cox claimed he was willing to defend his character in court, even if that risked further damage to his reputation.

The case did not appear at the next term of court. The district attorney refused to take the case to trial, claiming that in addition to a lack of witnesses there was a lack of documentary evidence substantiating the charge. In the few weeks prior to this term of

[1] "Dr. Cox denies the allegation and defies the alligator," *NWN*, 5 November 1887; and "Wives of Dr. Cox," *Milwaukee Sentinel*, 1 November 1887.

court, Mary Cox had asked for and been granted a divorce. The reporter for the *News* pointed out that this divorce decree could be used to prove that the marriage had been valid at the same time that Dr. Cox had married the Hayward wife. The divorce would not have been needed, after all, if a marriage to Mary had never occurred. The DA, however, produced a letter, written by Mary Cox and postmarked from St. Paul, asserting that she never really thought her marriage to the doctor was valid. Mary stated that she only brought the charge against the doctor because the family of the Eau Claire wife "had offered her a large sum of money to do so," and she only got the divorce to settle any question about her legal status.[2]

Although the case was never brought to court, the facts support the contention that Dr. Cox was a careless person, professionally and personally. He had clearly married Mary, despite her assertion that she never thought the marriage valid. She had been using the doctor's last name as her own, and she thought that a divorce might be necessary before marrying again. Moreover, the family of the Eau Claire wife cared enough about the case to make multiple trips to St. Paul and Hayward in order to exact some sort of justice. The doctor's argument that this was only an attempt to hurt his business interests carries little weight; he was not practicing in Eau Claire, and his Sawyer County business was booming.

This incident reveals a doctor that is quite unlike our image of what a doctor ought to be. The twenty-first century image of a doctor is one of a professional, both in his practice and in his business; doctors who experience such a public scandal as that of bigamy certainly lose social status and usually experience a loss of business. The

[2] "The Cox Case," *NWN*, 3 December 1887.

contrast between a trained, expert, and respectable twenty-first century physician and a nineteenth century doctor who was perhaps uneducated and certainly careless in his personal life reveals much about the professionalization of that occupation, a development that medical historians have tended to date to the first two decades of the twentieth century.

During those decades, Hayward not only experienced the professionalization of the medical system but was also experiencing a transition from an older concept of appropriate medicine to a new one. The new medical system that developed in many other areas of the country in the early 1900s is often identified as "modern western medicine." In Hayward, however, rural and frontier conditions stimulated a medical system that, even in the late 1910s, was neither modern nor traditional. In this transitional system, doctors retained attributes and personalities of traditional practitioners while they developed the connections and traits common in the medical profession half a century later.

In spite of the increasing professionalization and modernization of Hayward's doctors, the local population had a wider view of the medical community. Residents who were sick could choose from a wide variety of practitioners; the doctor with a medical degree and a membership in either the Wisconsin Medical Association (WMA) or the American Medical Association (AMA) was in direct competition with doctors with neither degrees nor connections. Both kinds of doctors competed with "alternative healers" who had reputations among the population for being very effective in their work. In addition, while modern pharmaceuticals were `certainly available and their use was supported by the degreed physicians, there was an abundance of patent medicines

available to consumers, often at a lower cost and often promoted by those same physicians. The result of this wide variety of choice in medical care was a dynamic medical system that was remarkably responsive to its patients' needs and desires, even if it was not always particularly effective in terms of cures.

The title "physician" has not always been associated with respectability, social authority, or great wealth. Historian Paul Starr points out that physicians of the Roman Empire "were primarily slaves, freedmen, and foreigners, and medicine was considered a very low-grade occupation." British physicians of the eighteenth century carried a social status below or "at the margins of the gentry class." And, twentieth century Soviet doctors earned, on average, "less than three-quarters" what a typical factory worker earned. In the late nineteenth century United States, many doctors "could hardly scrape together a respectable living," and their "personal authority" was dependent upon "imposing character and relations with patients."[3]

Starr goes on to argue that medicine became authoritative and respectable in the early twentieth century, a development that made physicians privileged members of American society and influential beyond their numbers. This transformation primarily occurred, he asserts, because of scientific successes in treating and curing diseases that, in the nineteenth century, usually resulted in death. Supporting those scientific successes was a growing solidarity among physicians towards creating legitimacy and exclusivity

[3] Paul Starr, *The Social Transformation of American Medicine*, 6-7, 21. For a general history of the professionalization of American medicine, see: Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995); E. Richard Brown, *Rockefeller Medicine Men*; James G. Burrow, *Organized Medicine in the Progressive Era*; Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993); John S. Haller, Jr., *American Medicine in Transition, 1840-1910*; and Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985).

through organization and government licensing. Doctors organized referral networks to support each other's authority over patient care. And, licensing ensured that medical practitioners who refused to join those networks and abide by the "rules" would not be allowed to practice. Starr argues, in effect, that doctors unionized. The result of unionization, scientific developments, and the support of an extensive government bureaucracy was the emergence of the modern American medical system.[4]

While Hayward claimed a large number of "resident" doctors between 1883 and 1920, most of these only stayed in the area for a few months. The few doctors who remained in the area for a long period of time formed the backbone of Hayward's unique medical community. Dr. John B. Trowbridge was the first of these, moving to the area in 1883 when the town was formed and remaining for 28 years, until his death in 1911. The second was Dr. Cox, who moved to the area in 1886, stayed until 1898, when he moved to the neighboring city of Spooner; Cox continued practicing in Hayward until his death in 1909. The third, Dr. George A. Grafton, moved to Hayward in 1899 and also remained until his death in 1911. All three of these physicians claimed medical degrees and membership in the WMA. And, all of them stayed current with scientific developments, often integrating those developments into their everyday practices. Finally, all became licensed by April 1900, when the State of Wisconsin required them by law to do so.

Wisconsin required licensing rather early; the trend towards strict licensing dependent upon a well-founded medical education became a national trend over the next decade. In 1906, the AMA sponsored an investigation into the condition of the country's

[4] Starr, *Transformation of American Medicine*, 9-13.

medical schools; this investigation, conducted by Abraham Flexner with the backing of the Carnegie Foundation for the Advancement of Teaching, concluded that while "America had some of the world's best medical schools," it also had "many of the worst."[5] State governments and licensing boards, embarrassed by the publicity the report generated, closed substandard medical schools and reduced their total number from 131 in 1910, when the Flexner Report was published, to 95 in 1915.[6] In fact, doctors Cox, Trowbridge, and Grafton all attended medical schools that survived the Flexner cuts and so would have had no problems being licensed with Wisconsin.[7]

The population of Hayward made note of the doctors' education and training, indicating that Hayward's residents regarded formal medical education as a valuable asset. An early biography of Dr. Cox, published in the local newspaper in 1898, pointed out that he had graduated from the "Medical College of Indiana" and that he had extensive experience with various government agencies, including stints on the US

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[5] *Ibid*., 120. For more on Flexner, see: Howard S. Berliner, *A System of Scientific Medicine: Philanthropic Foundations in the Flexner Era* (New York: Tavistock Publications, 1985); and Bonner, *Becoming a Physician*. "While most authors who discuss the events surrounding the Flexner Report would agree that it serves to demarcate the beginning of a new era in medical care, not all consider it to be the cause of the new era. Paul Starr convincingly argues that medical education was in the process of changing and the Flexner Report simply accelerated the rate of change. … Releasing the findings of the report to the public produced an immediate aftermath. The schools receiving poor ratings closed for lack of students, while the highly rated schools became more demanding; they raised entry requirements, expanded the curriculum to include more science and laboratory courses, extended the period of study, and so on." Ultimately, the Flexner Report was "the take-off point for a period of unprecendented scientific progress in medicine beginning with the reorganization of medical education but leading eventually to the reorganization of the medical profession itself." Grace Budrys, *Planning for the Nation's Health* (Westport, CT: Greenwood Press, Inc., 1986), 12, 28. I argue that the report also led to the strong reorientation of the profession towards scientific medicine and away from alternative, holistic approaches to health care.

[6] Starr, *Transformation of American Medicine*, 120.

[7] Trowbridge graduated from Rush Medical College in 1882, Grafton from University of Minnesota in 1899, and Cox from the "University of Indiana" in 1879. Trowbridge Obituary, *SCR*, 16 March 1911; "Obituary, George Grafton," *Wisconsin Medical Journal* [hereafter *WMJ*] 10, no. 3 (1911), 168; Cox Obituary, *SCR*, 7 October 1909.

Revenue Cutter Andy Johnson and as "US physician at C. de O. Indian Reservation."[8] When Dr. Grafton moved to Hayward, the newspaper described the recent graduate as "one of Hayward's strong young men, having had a thorough training in his profession."[9] And, while Dr. Trowbridge's credentials were not emphasized in public reports of his activities, his connections with fellow graduates of Rush Medical College were frequently mentioned.

As licensed physicians, all three doctors were part of a statewide medical community that worked towards creating solidarity among its members, supporting government licensing, and publicizing scientific developments and medical innovations. For the doctors of Hayward, this organization began at a regional level. By 1903, eight of the eleven licensed doctors of Sawyer county and the neighboring Washburn and Burnett counties had organized as the Washburn-Sawyer-Burnett County Medical Society (WSB) to advance "a full and frank interchange of views" in order to generate "unity and harmony in every phase of their labor."[10] Dr. Trowbridge was elected president of the three-county group, and Dr. Cox was elected his vice president. Both doctors read papers to the organization in the first few months of its existence, papers that clearly reflected the society's intent to create a sense of collegiality as well as to improve society members' medical knowledge. The Cox paper was "chiefly a resume of the early practice in Northern Wisconsin" in the 1880s, while Trowbridge's paper discussed the misguided tendency of doctors to confuse symptoms of pneumonia for other maladies,

[8] "Press History," *HR*, 9 June 1898. Dr. Cox's education is ambiguous; his obituary states that he graduated from the "University of Indiana."

[9] *HR*, 22 February 1900.

[10] *HR*, 10 September 1903.

including appendicitis and gall bladder attacks.[11] At subsequent meetings of the WSB, both doctors read papers presenting troublesome medical cases involving opthalmological and obstetrical issues, and the society as a whole discussed problems with maintaining the WSB objective in such a rural location.[12]

This fledgling society joined with other county societies to form a renewed State Medical Society of Wisconsin (SMS), which had first been organized a little more than sixty years earlier, in 1841. The SMS operated on the same general principles as the WSB; it worked to create unity among its members, it promoted its membership among the state medical community, and it lobbied for state legislation that would support its membership. And, at SMS meetings, members presented papers that outlined unusual or problematic cases and that promoted treatments that were uncommon but presumably effective. In June 1904, for example, Dr. Cox read a paper at the SMS that was similar to the one read at the WSB in 1903. In this paper, Cox advocated that the society set standard rates that doctors throughout the state should charge, and he encouraged his fellow physicians to be "up to date" in all current procedures. He also supported collaborative knowledge, describing his successes in the treatment of spasmodic croup, successes that only came after he adopted a simple but unusual treatment recommended to him by a doctor practicing in another northern Wisconsin city, Chippewa Falls.[13]

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[11] *WMJ* 1, no. 4, (1903).

[12] *WMJ* 2, no. 12, (1904); 3, no. 8, (1905); 6, no. 5, (1907).

[13] "Previous to this date [1898] I lost several little patients from this very trying condition in the treatment of which I had used nearly all the remedies known to the pharmacopoeia…" The successful treatment was a large dose of castor oil followed by some doses of "common balsam copaiba." Joseph P. Cox, M.D., "General Practice in Northern Wisconsin," *WMJ* 3, no. 11 (1905), 646. Copaiba is an oil that is "used as an expectorant, diuretic, and stimulant." William R. Hensyl, ed., *Stedman's Medical Dictionary*, 25th ed. (Baltimore: Williams & Wilkins, 1990), s.v. "copaiba."

Clearly, Hayward's doctors had recognized the value of making connections across their profession. These connections facilitated the distribution of practical and scientific knowledge. They limited competition between licensed physicians, creating a sort of professional monopoly. And, the connections buttressed state licensing, ensuring that, in ideal conditions, the monopoly would continue. Hayward, however, lacked those ideal conditions that would support the monopoly. It was remote and out of the direct sphere of influence of most organizations, like the SMS, that were headquartered in Madison or Milwaukee. Hayward's doctors had plenty of competition from practitioners that had no place in the monopoly.

The least threatening of these competitors were those that passed through Hayward in a virtual stream. The city's newspapers continually reported on "highly recommended" new physicians who were "moving to town" to "set up a practice." The majority of these new doctors stayed in town for less than a year, moving along with Hayward's unsettled population to other frontier locations. Dr. E.E. Torwick treated the Scandinavians in town in 1896 and 1897 but was traveling in Norway for much of that time.[14] Another Scandinavian doctor, Dr. P.M. Hotvedt, was reported to be moving to town in 1902, but apparently he did not stay, as he never signed any birth or death records or advertised as a local doctor.[15] Dr. J.W. Wells practiced in town only a year and a half, from late 1887 to the middle of 1889.[16]

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[14] Torwick arrived in March, 1896, but left for Norway only three months later for a six week trip. By December of that year, Torwick was no longer advertising in the *HR*. In early March, 1897, the *HR* reported him as having returned, but by July, 1897, he had again left town, this time permanently. *HR*, 26 March; 20 August 1896; 4 March 1897.

[15] *HR*, 20 March 1902.

[16] *NWN*, 28 January 1888; 25 May 1889.

Doctors who claimed specialties, especially oculists, also passed through Hayward frequently but rarely settled there. Prof. Strassman, for example, who claimed to be from Berlin, Germany, passed through in July 1898, and advertised that he was a "specialist" in the treatment of "diseases of the eye and ear and … of catarrh, deafness and blindness."[17] Only two weeks later, Prof. Jim Cernaghan, of Bismarck Germany, passed through, promoting his "complete line of adjustable eye glasses." In March 1904, oculist Dr. Matteson, who received a Master of Arts and a "medical education" at the University of Minnesota, decided to make Hayward his permanent home. Matteson teamed up with Dr. Grafton and began planning to establish a much-needed hospital in the city. Only a month and a half later, however, Matteson "severed his connection" with Grafton and the proposed hospital and left town "to look up another location."[18]

A few doctors stayed a bit longer, but their Hayward careers were no more exceptional. Dr. Oscar Gade, for example, moved his practice to Hayward in 1898 and stayed for a little more than a year.[19] He then moved, traveling among several towns that were all within a fifty-mile radius. In January 1900, Gade appeared before a judge in Ashland, pleading for assistance, as he was destitute and insane. The judge delayed judgment, as that would obligate the county to provide support and hospitalization. Gade was convinced to return to Hayward and reapply for assistance there because Hayward

[17] *HR*, 14 July 1898. "Catarrh" is hay fever. *Stedman's*, s.v. "catarrh."

[18] *HR*, 28 July 1898; 24 March; 5 May 1904.

[19] *HR*, 6 January 1898. By May, town gossip was that Gade was leaving, but Gade claimed this was "false." *HR*, 12 May 1898.

was the last place where he had established residency. However, his request for assistance also stalled in Hayward's courts. Eventually, Gade moved from the area.[20]

Another physician who practiced locally, Dr. Geo. E. Davidson, became newsworthy in 1902. Davidson was a government physician, based in Ashland, who treated reservation Indians throughout Northwestern Wisconsin. In March 1902, the muckraking editor of the *Enterprise* accused Davidson of engaging in an illegal liquor trade on the reservation and using his position as physician to cover his activities. Davidson claimed that this was an "unconditional lie," and he argued that the government farmer carefully controlled any medicines that he did take to the reservation, including those that had an alcohol base.[21] Seven months later, Davidson again made news when he was found dead of an overdose in his room at an Ashland hotel. On his bedside table was an empty medicine bottle, which had almost certainly contained an opiate.[22] By all accounts, Davidson was a capable physician who would have certainly known correct opiate dosage. An accidental overdose, therefore, would have been unlikely.

More troublesome for Hayward's resident physicians were the itinerant healers who operated just above the law.[23] They advertised themselves as doctors, yet they were clearly not registered or licensed by the state. Prof. Lillian A. Grow, for example, began

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[20] *HR*, 25 January 1900.

[21] The government farmer was an agent of the Office of Indian Affairs who was supposed to monitor the activities on the reservation and help the reservation Indians learn how to become fully independent American citizens.

[22] *HE*, 19 March 1902; *HR*, 20 March; 9 October 1902.

[23] For general histories of alternative medicine in the United States, see: Norman Gevitz, ed., *Other Healers: Unorthodox Medicine in America* (Baltimore: Johns Hopkins University Press, 1988); and James C. Whorton, *Nature Cures: The History of Alternative Medicine in America* (New York: Oxford University Press, 2002).

visiting Hayward in November 1903 and continued those visits over the next few months. Her advertisement claimed that she had "no superiors and few equals among magnetic healers" and that "the many cures placed to her credit [were] sufficient evidence of her ability to cope with diseases." In a nod towards the public's growing desire for official credentials, Grow advertised herself as "a graduate of the El Dorado School of Magnetic Healing, Eldorado Springs, MO., and of the Lamphear Institute of Eau Claire, Wis."[24] Evidently successful in her visits, Grow asserted she would continue visiting Hayward until "her work [was] completed which will in all probability require a couple of months."[25]

Another itinerant healer, advertising as the "Battle Creek Doctor," who claimed that he was "licensed by the State for the cure of all Nervous and Chronic Diseases of Men, Women and Children," traveled through the area in 1910. This doctor claimed that he was an expert in treating diseases as varied as rheumatism, diabetes, and bedwetting, and he could avoid resorting to operations in his treatment of appendicitis, tumors, goiters, and piles.[26] The Battle Creek Doctor announced that patients who had not had success being treated by "other physicians, sanitariums, [or] patent medicines" should come to see him.[27] Like Grow, the doctor was clearly successful in finding patients who

[24] *HR*, 5 November 1903.

[25] *HR*, 7 January 1904.

[26] "Piles" are hemorrhoids. *Stedman's*, s.v. "piles."

[27] *SCR*, 27 October 1910. It is likely that the "Battle Creek Doctor" was unconnected to John Harvey Kellogg, who had opened a nationally renowned sanitarium in Battle Creek, Michigan (see Chapter 6). This itinerant healer was probably only cashing in on Kellogg's reputation.

were willing to pay for cures for, among others, bedwetting, appendicitis, and piles, as he continued his nomadic practice in northern Wisconsin for at least a year.

It was not only the itinerant practitioners that skirted the law; resident healers also carried on thriving businesses that were clearly less than legal. One who challenged the licensed medical community into action was Dr. John Till, an immigrant with a vague claim to have come from central Europe. (Figs. 2.1-2.2) Till asserted he had been trained in traditional plaster treatments by a doctor in Europe, following the traditional belief that all illnesses were caused by poisons in the body. [28] To cure an illness, one only had to determine what poison was causing it and then prompt the body to excrete the poison.

People from throughout northern Wisconsin traveled to Almena, about 60 miles from Hayward, to have Till apply his plasters; the "doctor" frequently worked from dawn until after dark serving this mass of patients. When a patient entered Till's home, the "plaster doctor" would

> feel of their jugular vein and oftentimes would tell them their trouble without them saying a word. The suffer's [sic] back was laid bare. Till would take a sponge and [smear] his croton oil concoction from neck to base of the spine. [His assistant] in the meantime would sew in the person's garment some cotton batting. This would soak up the running matter from the inflamed skin. In time the back would be almost like raw beef. Then a festering would take place. The suffering would often draw screams and moaning. The longing to be through with the treatment and have the back rid of the pain was intense.[29]

[28] A "plaster" is a "solid preparation which can be spread when heated, and which becomes adhesive at the temperature of the body; … when medicated, to redden or blister the skin or to apply drugs to the surface to obtain their systemic effects." *Stedman's*, s.v. "plaster."

[29] Somerset Historical Society, *The Saga of Somerset, 1956*, WHS Area Research Center, River Falls. Croton oil is a "fixed oil expressed from the seeds of *Croton tiglium*, an East Indian shrub; used as an irritant purgative, and externally as a counterirritant" and as a blister agent. *Stedman's*, s.v. "croton oil."

Till did not charge his patients for this service; to do so would clearly violate the laws regulating medical care. Instead, Till's patients brought donations, "frequently a silver dollar," that they would drop into a large pail. This system had, in fact, saved Till when he was charged with malpractice. Till had so many patients that at one point he was receiving $1,500 a week in "donations."[30]

Till practiced his plastering from 1905 to 1911, with frequent vacations that coincided with investigations by state medical authorities. In 1911, Till was investigated by Minnesota authorities in St. Paul for the death of a woman, which had been attributed to "septic poisoning, induced by application of 'Dr.' Till's plasters." The authorities were satisfied that "criminal action could be brought against" him, as he had "applied one of his plasters to" the woman's back a month before her death. Adding to the evidence against Till, there were "two additional deaths, which physicians ascribe to the use of the Till plasters" which were "recorded in the office of the Minnesota state board of health." Minnesota and Wisconsin officials began collaborations in arranging the legalities of an arrest and trial for manslaughter, but the charges were eventually deemed impractical. In response to the accusations, Till was "amused … stating he expected nothing better. He declared the physician … who caused the sensation in the first place, admitted he injected something into" the woman's "back that caused boils. Till denied that he had anything to do with the treatment of the dead woman that caused here [sic] death."[31]

Although formal charges for the woman's death were not filed, both Wisconsin and Minnesota medical authorities were concerned about the larger implication on the

[30] *SCR*, 26 December 1907; 31 August; 7 December 1911.

[31] *SCR*, 31 August 1911.

medical profession. Some of Till's patients had died, but even licensed doctors had patients who died because of poorly performed medical procedures. In addition, while the publicity about Till's problems only seemed to bring him more business, publicity about problems in the licensed profession appeared to drive patients towards extra-legal practitioners like Till. Compounding the trouble were the licensed physicians who insisted on practicing old-fashioned medical techniques that clearly caused increased morbidity and mortality. After Dr. Cox had presented a paper to the SMS in which he argued for antiseptic methods in assisting childbirth, for example, a number of the doctors attending the session argued against antisepsis.[32] Even more disconcerting was the fact that Till was collecting enough silver dollars in a bucket every few days that it reportedly took two men to carry the bucket to the bank.[33] Till was, in short, threatening the doctors' reputation and livelihood.

The threat to the reputation of the medical profession as a whole was clearly evident in the practice of dentistry. Hayward's resident doctors practiced dentistry when they had to; Trowbridge himself pulled teeth for at least one patient in 1894. More common was a partnership between a resident doctor and an itinerant dentist. From 1894 to 1899, Dr. Dietz had office hours every two or three weeks in Dr. Trowbridge's office.

[32] Antisepsis is a process of disinfection of the sickroom. *Stedman's*, s.v. "antisepsis." By the time Cox gave his paper in 1905, arguments against antisepsis within the medical establishment were becoming infrequent. However, after Cox's presentation, there were several physicians from the Wisconsin north woods who had doubts. Dr. E.L. Boothby of Hammond argued that "I do not think there are many cases of real septic infection in those cases where we find dirty beds, dirty skin and dirty clothes. In the country there is certainly an immunity among mothers that we must take into consideration." Dr. J.M. Dodd of Ashland asserted that while "aseptic obstetrics is truly ideal but it is not absolutely practicable, which we must conclude when we remember how universal is the presence of germs… We are taught, and have good reason to believe, that infection which causes puerperal septicemia is introduced from without by the attendant physician or nurse; but we cannot say with absolute assurance that this is correct." Joseph P. Cox, M.D., "Aseptic Obstetrics", *WMJ* 4, no. 4, (1905).

[33] Somerset Historical Society, *The Saga of Somerset, 1956*, WHS Area Research Center, River Falls.

Reflecting Dr. Cox's personal tendency towards inconstancy, dentists associated with that doctor rarely remained allied with him for more than a year. One incident, in particular, illustrates the awkward situation that a partnership between dentist and physician could cause. In January 1898, a new dentist, Dr. Herrick, entered into a partnership with Dr. Cox and began practicing at Cox's office. The local newspaper reported this fact along with, a few news items later, the detail that "Dr. Cox [had] been confined at home most of the week with a sore jaw, caused by extracting a tooth."[34] Within a few days, Cox traveled to St. Paul for more professional treatment, which was required as a consequence "of having two or three teeth extracted."[35] Two weeks later, Cox was still indisposed, the news again reporting the connection between this sickness and the tooth extraction. Cox was finally able to see patients again after three weeks, and on the next visit Dr. Herrick made to Hayward, the dentist located his practice at the drug store instead of at Cox's office.[36] Within six months, Cox had entered into a partnership with a different dentist, apparently deciding that a partnership with a dentist that caused three weeks of pain would not be good for business.

Partnerships with alternative healers were not always bad for business. In fact, regarding obstetrics, historians have pointed out that doctors encouraged the practice of midwifery for various reasons until well into the twentieth century. Some doctors felt that assisting in childbirth was not a medical procedure; it was less than medical, and so the midwife presented no professional threat until obstetrics became a true medical

[34] *HR*, 6 January 1898.

[35] *HR*, 13 January 1898.

[36] *HR*, 3 March 1898.

specialty. Other doctors saw childbirth as a valid medical situation but were too busy to assist in each case; these doctors tolerated the midwife as a lesser associate and would come to the midwife's aid when the childbirth was particularly difficult.[37]

Charlotte Borst, in her book, *Catching Babies: The Professionalization of Childbirth, 1870-1920*, argues that there were three kinds of midwives in Wisconsin during that fifty-year period. The first, the neighborhood midwife, was not formally trained; instead, this typical midwife was a mother who, in assisting neighbors or kin, had discovered she had a talent for midwifery. By the turn of the century, this type of midwifery was in decline and was being replaced by the apprentice midwife, who had trained under the direction of male physicians. The final type of midwife was formally educated in midwifery schools, which were common in Europe. Thus, many of the formally educated midwives were immigrant women.[38]

In fact, most Wisconsin midwives were first or second generation immigrant women who served their own communities. This custom became less prevalent as the medical profession developed and as obstetrics became a specialty. Borst argues, however, that "midwives in Wisconsin were not pushed out of practice by elitist or

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[37] For a history of midwifery in the United States, see: William Ray Arney, *Power and the Profession of Obstetrics* (Chicago: The University of Chicago Press, 1982); Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson, with the assistance of Margaret Brennan, ed., *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London: Routledge, 1990); Irving S. Cutter and Henry R. Viets, *A Short History of Midwifery* (Philadelphia: W.B. Saunders Company, 1964); Raymond G. DeVries, *Regulating Birth: Midwives, Medicine and the Law* (Philadelphia: Temple University Press, 1986); Jean Donnison, *Midwifes and Medical Men: A History of Inter-Professional Rivalries and Women's Rights* (New York: Schocken Books, 1977); Barbara Ehrenreich and Derdre English, *Witches, Midwives and Nurses: A History of Women Healers* (The Feminist Press at CUNY, 1972); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986); and Dorothy C. Wertz, and Richard W. Wertz, *Lying-In: A History of Childbirth in America* (New York: Schocken Books, 1979).

[38] Charlotte Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Cambridge: Harvard University Press, 1995).

misogynist obstetricians [but] instead, their traditional, artisanal skills ceased to be valued by a society that had come to embrace the model of disinterested, professional science."[39] In a study of midwifery among southern black women who had migrated to Pittsburgh, Carolyn Leonard Carson supports Borst's contention. Instead of continuing their reliance on kinship networks and the "granny midwife," the migrants chose to rely on physicians and hospitals for their health needs. This choice to purchase professional medicine was supported by the efforts of the Urban League, an organization that actively promoted health services as a form of racial uplift.[40]

Although informal and unregistered midwives likely lived in Hayward from 1883 and on, it was 1898 before a midwife moved to town who was willing to advertise. In January of that year, a Mrs. H.O. Hanson came to town from Cloquet, Minnesota, about 90 miles away, and advertised herself as a "graduate and a successful midwife."[41] Within two weeks, Mrs. Hanson decided to settle in Hayward permanently, and almost immediately, she began assisting in births. Although Dr. Cox was one of Hayward's permanent doctors and was reputed to have taken an apprenticeship with Dr. Marion Sims, America's eminent gynecologist, in the 1870s, Dr. Cox did not register one birth with the Sawyer County clerk the whole year of 1898. Dr. Trowbridge, on the other hand, signed 44% of all birth records between spring of 1898 and the beginning of 1901,

[39] *Ibid*., 11.

[40] Carolyn Leonard Carson, "And the Results Showed Promise ... Physicians, Childbirth, and Southern Black Migrant Women, 1916-1930: Pittsburgh as a Case Study," in *Women and Health in America*, ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1999).

[41] *HR*, 13 January 1898.

while Mrs. Hanson signed 56% of the records. For 1901, the same percentages held true.[42]

Trowbridge and Hanson did not advertise together, nor did Hanson advertise at all after her first few months in town. Trowbridge was certainly not the kind of doctor who left all easy births to the midwife and only handled the difficult births, since it is unlikely that a full 44% of all births would be difficult. And, Trowbridge was certainly busy and successful enough to have been able to afford to steer clear of obstetric cases. Instead, it appears that Trowbridge had accepted childbirth as a situation with a legitimate place for the physician, and he had recognized Hanson as a colleague who had a valid place in the birth room, if not in the ranks of the WSB or SMS. Hanson's presence did not infringe upon Trowbridge's income; there were enough births for both practitioners to attend. And, it is clear that the women of Hayward welcomed the midwife as a qualified member of the medical community.

Hayward's doctors, then, defined their medical community as primarily dependent upon mutual association. They were members of medical societies, both regional and statewide. And, they eventually were designated by the state to be members of a licensed and regulated community. They worked to exclude practitioners, like Till, who cut into their business, but they accepted healers and doctors, like Hanson and Dietz, whose presence was either neutral or beneficial. The problem was that practitioners like Till were accepted by the community, which was plainly willing to search out doctors, healers, and their remedies to the detriment of the resident physicians' businesses.

[42] Between 1898 and 1901, Trowbridge signed for 64 births, while Hanson signed for 81. In 1901, Trowbridge signed for 22 and Hanson signed for 27. "Pre-1907 Wisconsin Births," WHS.

At times, the doctors that the community sought out were not threatening towards Hayward's physicians' businesses. Residents who had the resources to do so often traveled to see specialists in Ashland, Eau Claire, or St. Paul. Doctors in those cities acquired reputations for being able to treat difficult cases, even if they were not specialists. Hayward's own doctors, in fact, often called those doctors in for consultations. Dr. Trowbridge, for example, called Dr. J.V.R. Lyman, a noted surgeon in Eau Claire, to consult in the treatment of the young son of Mr. and Mrs. John Powers in 1896.[43] In 1898, Trowbridge and Lyman again collaborated, operating together on Capt. C.E. Rogers.[44] The fact that residents would go to see doctors in other areas when local doctors were unable to provide adequate treatment was troubling; it highlighted the local physicians' inadequacies. However, the practice was common enough not to be strange, and it was limited to the residents who had the money to travel. Outside consultation, therefore, did not threaten the doctors' livelihood. Moreover, those specialists confirmed the local doctors' procedures and diagnoses often enough to support the local practices. During an epidemic of scarlet fever in 1902, for example, Dr. Ellison, of Chippewa Falls, said that the local doctors were "up-to-date in every respect on the epidemic question." The local newspaper went on to report that Hayward's doctors were doing "everything that can be done."[45]

Too often, however, Hayward's citizens sought out health care and health care providers that directly affected the local doctors' bottom lines. The longest standing

[43] *HR*, 27 February 1896.

[44] *HR*, 7 July 1898.

[45] *HR*, 7 August 1902.

source of alternative health care in the community advertised in the same newspaper that promoted the local doctors' practices. Patent medicine ads filled the back pages of the local papers, advertising cures for everything from catarrh, malaria, and eczema to dropsy.[46] Perhaps most well known among these ads were the ads for the *Common Sense Medical Advisor*, also known as the *People's Medical Advisor* (hereafter *Advisor*), and for Lydia Pinkham's "Vegetable Compound." The Pinkham compound, sold through mass newsprint advertising since the 1870's, claimed to cure "female troubles," a euphemism that covered almost everything from uterine prolapse, cancer, and kidney troubles, to general feelings of weakness and depression.[47] Dr. R.V. Pierce, who was also the operator of the World's Dispensary Medical Association and the Invalids' Hotel and Surgical Institute in Buffalo, NY, published the *Advisor*, a thick book of advice regarding health care situations. Essentially, the *Advisor* couched sensible advice in a massive ad for patent medicines and for the sanitarium; Dr. Pierce enticed his customers to pay for the advertising as well as for the advice.[48] A bestseller, the book had sold more than 2 million copies before 1910.

As astute businessmen, Hayward's physicians recognized the competition that patent medicines represented, and they arranged circumstances to be able capitalize on that market. Dr. Trowbridge opened a drugstore soon upon his arrival to Hayward along with a partner, E.R. Sherburne. In addition to selling sodas, wallpaper, trinkets,

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[46] Dropsy is water retention, sometimes also called edema. *Stedman's*, s.v. "dropsy."

[47] Sarah Stage, *Female Complaints: Lydia Pinkham and the Business of Women's Medicine* (New York: W.W. Norton & Company, 1979).

[48] R.V. Pierce, M.D., *The People's Common Sense Medical Adviser in Plain English: or, Medicine Simplified*, 46th ed. (Buffalo, NY: World's Dispensary Printing Office and Bindery, 1895).

cosmetics, and the type of medicines that would eventually be approved by the FDA, Trowbridge & Sherburne sold patent medicines very similar to those that were advertised in the newspaper.[49] When Sherburne passed away, Trowbridge continued to operate his drugstore with Tomkins, and when Trowbridge passed away, Tomkins maintained the business alone. The drugstore, then, represented the same kind of long-term stability in Hayward's medical community that Trowbridge himself symbolized. Long after the AMA began to work to make patent medicines illegal, Haywardites continued to treat them as legitimate, in large part supported by the image of legitimacy created by Trowbridge's drugstore.

Dr. Cox also jumped into the patent medicine business. True to his personality, however, Cox's venture was fickle, erratic and, ultimately, a failure. Soon after arriving in Hayward, Cox began traveling throughout the region selling a concoction only described as "Cox's preparation."[50] Within a year, Cox had stopped traveling to promote his medicine, and it was no longer mentioned in the local press. Like all of Dr. Cox's hospital ventures, the undertaking was short-lived. [51]

By 1898, when he moved to Spooner, Cox's personal and professional reputation in Hayward was discredited by his private and public failures. As the local physician who made the most open effort to be identified as "modern," Cox's questionable reputation extended to the image of modern scientific medicine among Hayward's local population. Modern medicine did not seem to be sensible or reliable. Given a choice,

[49] See, for example, issues of the *HR* in September 1895; 24 June 1897.

[50] See *NWN* 1886, 1887.

[51] See Chapter 1.

Haywardites continued to visit alternative healers like Till, who claimed to have inherited old world wisdom, or Mrs. Hanson, who demonstrated her training and expertise with every birth she attended. Or, they patronized country doctors like Trowbridge, who injected modern scientific knowledge with a healthy dose of folk wisdom and faith and who were dependable and consistent in their message. When Trowbridge died after a long battle with cancer in 1911, the locals described him as "whole-souled," "unassuming," and full of the "abiding faith of a child" and quoted his last words as "It's all right. God never makes mistakes."[52] The health care system in Hayward, then, was neither wholly modern nor traditional; it was a system based on practicality and common sense and one that was incredibly responsive to the demands of the market.

[52] *SCR*, 16 March 1911.

Fig. 2.1
"Doctor" Till in a formal pose, wearing a suit and tie – suitable attire for a medical "specialist."[53]

[53] "John Till, the Plaster Specialst [sic]," (H.H. Denison: Barron, WI) 1908. Postcard from author's collection."

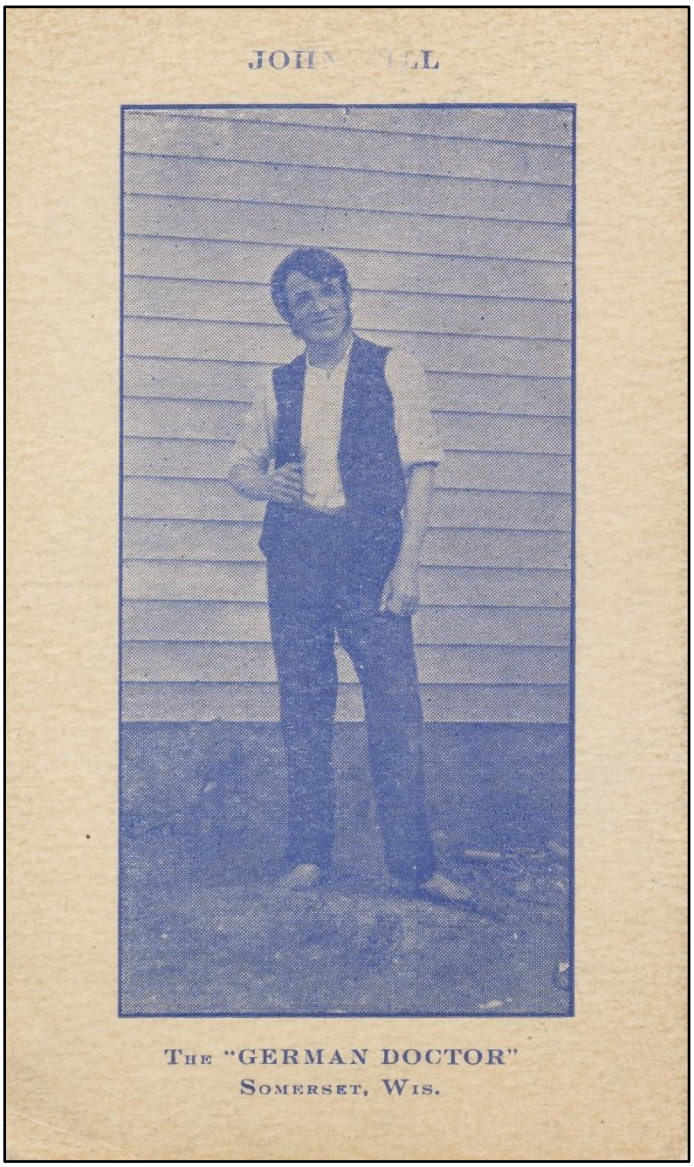

Fig. 2.2
"Doctor" Till wearing casual attire with his sleeves rolled up – clearly an appeal to the immigrant working class.[54]

[54] "The 'German Doctor' Somerset, Wis.," n.d. Postcard from author's collection.

CHAPTER THREE:
SACRED TEAS, A SISTERS' SCHOOL, AND AN INDIAN PRIEST: HOLISM AND MODERNITY COLLIDE

> "You will recover; you will walk again. It is I who say it; my power is great. Through our white shell I will enable you to walk again."[1]
>
> "we maintain water to be capable of curing every curable disease, as its various applications, properly applied, directly attack the root of the evil"[2]

On January 18, 1888, Dr. Cox traveled from Hayward to the Lac Courte Oreilles Reservation in order to treat an Ojibwe logger who had met with an accident. The man, identified only as the "son of Shabogesic," had suffered a "compound, comminuted and badly lacerated fracture of the lower third of the thigh."[3] Cox saw to it that the wound was "washed with soap suds and bi-chorlide" and that the bones were reset as well as could have been done, after which the young Ojibwe's leg was elevated. The treatment was complex; it took Cox two hours to complete. Satisfied that he had done all he could, the doctor left the patient in the care of one of the "female nurses of the tribe" and then returned to town.[4]

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[1] Midewiwin song asserting that a person who is unable to walk will recover "through the power of the white shell … the emblem of the Midewiwin." quoted in: Frances Densmore, *Chippewa Customs* (Washington: Smithsonian Institution, 1929; reprint, St. Paul, MN: Minnesota Historical Society Press, 1979), 45.

[2] Sebastian Kneipp, *My Water-Cure as Tested through More Than Thirty Years and Described for the Healing of Diseases and the Preservation of Health*, trans. A. de F., 7th ed. (Edinburgh: William Blackwood and Sons, Ltd, 1891), 9.

[3] In other words, the bone was broken into several pieces, and at least one piece of the bone had broken through the skin. *Stedman's*, s.v. "fracture: compound, comminuted."

[4] Cox, "General Practice in Northern Wisconsin," 643-44.

At about 2 o'clock the next morning, Cox was awakened by a tribe member with the message that the patient was dying. Cox hurried to his bedside, "arriving at his home shortly after daylight." There, the doctor found his patient "in a condition of most excruciating pain, all stitches … torn loose, the leg … out of position, extension cord cut and wound buried under a very generous poultice of Indian cow manure."[5]

In his treatment of the young Ojibwe, Cox had wrongly assumed there "to be no difference of opinion in the modus operandi of the case" between him and the "Medicine Man of the tribe." The Ojibwe medicine man, Neweosh, had "practiced his profession successfully" in the area for at least the last 50 years and had already begun to treat Shabogesic's son," according to Cox. (Fig. 3.1) Yet, Neweosh had "gracefully turned the case over" to Cox when the doctor rushed to the patient's bedside at the request of an observer of the original accident. And, when Cox had presented his opinion regarding the case, Neweosh had also presented an opinion, one that Cox had not understood; Neweosh spoke Ojibwe, and Cox did not.[6]

As Cox watched the young patient die, he learned that before he had traveled a mile from the patient's bedside, Neweosh had directed the "nurse to cut the extension cord" holding the leg in suspension. Neweosh himself cut the stitches that closed the wound "with his own trusty hunting knife." The poultice of manure was applied, then, to an open wound and, in all likelihood, to exposed bone marrow.[7] The original injury

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[5] A poultice is "a soft magma or mush prepared by wetting various powders or other absorbent substances with oily or watery fluids, sometimes medicated, and usually applied hot to the surface; it exerts an emollient, relaxing, or stimulant, counterirritant effect upon the skin and underlying tissues." *Stedman's*, s.v. "poultice."

[6] Neweosh, also spelled as Neweiash.

[7] Cox, "General Practice in Northern Wisconsin," 643-44.

might have been fatal, in and of itself; the introduction of this source of contagion to the patient's system almost certainly guaranteed the final outcome.

The "difference of opinion" between the doctor, who had trained at the "Medical College of Indiana" only nine years earlier, and the Ojibwe medicine man, who had probably trained at the feet of his father and grandfather half a century earlier, was characteristic of the conflicts that existed regarding health practices on the Ojibwe-Anglo frontier.[8] Cox was part of a medical system that was rapidly developing; even in the late 1880s, it was grounded more in scientific discoveries and theories than on traditional remedies like teas, broths, and prayer. Neweosh, on the other hand, was part of a system of health care that placed great value in traditional remedies and was holistic in its recognition of the connection between man, his environment, and his social relationships. When these two systems collided in Northern Wisconsin, they did so on an unequal footing; scientific health care certainly had the power and support of the federal and state governments, while traditional Ojibwe medicine was increasingly confined, even within the reservation system. When Shabogesic's son broke his leg, both Neweosh and Cox were called to care; Cox arrived later, probably only because the trip to the reservation took several hours. But when Cox entered the room, Neweosh stepped back and watched for two hours while Cox set bones, sewed muscle and skin, and manufactured a makeshift suspension system.

By the early 1920s, the Ojibwe medicine man had been pushed almost completely out of the health care picture on the reservation, as LCO Ojibwe began to recognize a distinction between mind and body that was characteristic of the new scientific medicine.

[8] Cox graduated from the University of Indiana in 1879. "Obituary" *SCR*, 7 October 1909.

The traditional Medicine Man became recognized as the appropriate healer of the spirit, while the medical man at the government clinic treated the broken bones.

The transition from a holistic view of health and illness to a view that engaged with scientific medical systems was not an easy one, nor was the outcome of the encounter predetermined. For three decades following the broken leg encounter between Dr. Cox and Medicine Man Neweosh, the medical systems they represented – scientific and traditional – and the healthcare workers who advocated those medical systems continued to be in conflict on the LCO. In this environment, it was possible that a traditional approach to health care could have endured on the LCO long past the time at which most Americans embraced scientific medicine, and holistic health care had the potential to be integrated with the new modern medicine. While scientific medicine had the backing of the state and federal governments, traditional Ojibwe health care on the LCO reservation had gained an unexpected ally when an order of Franciscan nuns, who themselves embraced a holistic approach to health care, decided to establish a mission school there. Scientific medicine overcame the holistic approach on the LCO only after the nuns left and the local priest demanded that the federal government improve the standards and availability of modern scientific medicine on the reservation.

The Ojibwe who lived at LCO were, like the European-Americans living in Hayward, relative newcomers to Northern Wisconsin; as recent migrants, the LCO Ojibwe maintained active cultural and social connections to other tribes who had also recently moved to the larger region. They were semi-nomadic hunters, fishers, and gatherers who had probably migrated to northwestern Wisconsin in the mid-1700s as part

of a larger Algonquian migration.[9] As participants of that larger migration, the Ojibwe traded customs with other tribes that migrated. For example, the Ojibwe "celebrate[d] the Feast of the Dead, a ceremony perhaps borrowed from the Ottawa, who in turn, may have borrowed it from the Huron, an Iroquoian-speaking people."[10] While many of their migrating cousins were able to create less nomadic lifestyles in more abundant environments, the Ojibwe remained semi-nomadic because of the scarcity of a steady supply of food in the area. As such, the Ojibwe continued to have regular contact with other tribes and to exchange customs.

One custom that the Ojibwe engaged in, the Midewiwin ceremony, has a particularly ambiguous origin.[11] Citing similarities between the Midewiwin ceremony and elements of Christianity, some historians and anthropologists argue that the practice likely developed after European contact.[12] Other scholars argue that the ceremony developed much earlier and as the Ojibwe continued their practice of trading customs, they "traded" elements of Christianity into their belief system.[13] And, at least one

[9] Walker D. Wyman, with Kurt Leichtle, *The Chippewa*, 34; and Bieder, *Native American Communities in Wisconsin*, 30-1.

[10] Bieder, *Native American Communities in Wisconsin*, 32.

[11] The Midewiwin is sometimes called the Medicine Lodge ceremony or the Medicine Dance.

[12] For example, see Harold Hickerson, *The Chippewa and Their Neighbors: A Study in Ethnohistory* (New York: Holt, Rinehart, and Winston, Inc., 1970), 52-54, 59-63; and Felix Keesing, *The Menomini Indians of Wisconsin: A Study of Three Centuries of Cultural Contact and Change* (Philadelphia: American Philosophical Society, 1939; reprint, New York: Johnson Reprint Corporation, 1971), 48-49.

[13] See K.E. Kidd, "A Radiocarbon Date on a Midewiwin Scroll from Burntside Lake, Ontario," *Ontario Archaeology* 35 (1981), 41-43; and Bruce G. Trigger, *Natives and Newcomers: Canada's "Heroic Age" Reconsidered* (Montreal: McGill-Queen's University Press, 1985), 117.

anthropologist has argued that part of the tradition originated with the Dakota Sioux.[14] No matter its original source, the Midewiwin society was well established on the LCO by the late 19th century.

The Midewiwin is, in total, a religious and spiritual worldview that has a focus on healing rituals. Its beliefs explain the origin of the world and of the Ojibwe people. According to Midewiwin tradition, Mide Manido, the Grand Medicine Spirit, saw the weaknesses and vulnerabilities of the Ojibwe and decided to present a gift to them: the ability to cure disease and thus prolong life. Mide Manido sent the people an Otter, who brought them totems and knowledge of Mide Manido's secrets. Among the totems that the Otter brought were items that should be used in healing the sick, including the sacred drum and tobacco. [15] Most important among the totems was the Migiis Shell, a white shell that channels the power of Mide Manido.[16]

Individual Ojibwe who wanted to become members of the Midewiwin underwent specialized training and had to be initiated in special ceremonies that were only performed semi-annually. As members of the Midewiwin learned more about the society and received the knowledge that had been passed to the Ojibwe by the Otter, including the names and uses of various herbs in treating the sick, they advanced in degree and

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[14] Robert E Ritzenthaler, "Chippewa Preoccupation with Health; Change in a Traditional Attitude Resulting from Modern Health Problems," *Bulletin of the Public Museum of the City of Milwaukee* 19, no. 4 (1953), 182.

[15] Densmore, *Chippewa Customs*, 87.

[16] For more about the Midewiwin, see: Allen Delano Blakeslee, *The Religious Customs of the Ojibway Indians* (Hayward: Journal-News Print, 1890); Frances Densmore, *Chippewa Customs*; Harold Hickerson, *The Chippewa and Their Neighbors*; Walter James Hoffman, *The Mide'wiwin: "Grand Medicine Society" Of the Ojibway* (Honolulu: University Press of the Pacific, 1891; reprint, 2005); Robert E Ritzenthaler, "Chippewa Preoccupation with Health"; and Walker D. Wyman, with Kurt Leichtle, *The Chippewa*.

power. And attendance at the semi-annual ceremonies was essential, as it "renew[ed] the spirit power" of the society's members.[17] (Fig. 3.2) These ceremonies and accompanying dances gave structure to the Ojibwe community and allowed members of that community the opportunity to make connections with Mide Manido, through which life was "restored and prolonged."[18] The ceremonies also created strong bonds between individual tribes, again reinforcing the relationships of trade across the region.[19] Finally, the rituals were accompanied by oral tradition that encompassed the history of the tribe itself.[20]

A Midewiwin practitioner learned, in his or her studies, how to administer remedies for the sick and the ailing. At times, mere initiation into the society was enough to cure the sick; "this belief [was] so strong that persons too ill to be carried to the Mide lodge were initiated by proxy."[21] More often, sick members of the tribe approached practitioners for treatments that included instructions for living an ethical life and administration of various herbs. The system of ethics that directed Midewiwin life was straightforward: "Rectitude of conduct produces length of life, and … evil inevitably reacts on the offender."[22] The system of herbal remedies that also prolonged Ojibwe life was much more complex. (Table 4) First degree members of the society only were

[17] Densmore, *Chippewa Customs*, 87.

[18] William W. Warren, *History of the Ojibway People*, 78-79.

[19] *Ibid*., 100.

[20] Densmore, *Chippewa Customs*, 8.

[21] *Ibid*., 44-45. Because Midewiwin practitioners could be male or female, LCO tribe members were more willing to accept the School Sisters of St. Francis as having health care authority than their neighbors in Hayward were at the same time.

[22] *Ibid*., 86-87. The manido is the spirit.

taught the basics; continued learning was expected, and members with high degrees had extensive knowledge of the environmental resources available to the Ojibwe. (see appendix…)

As hunter-gatherers, groups of Ojibwe historically tended to be small; a typical community consisted of between a "few families to several hundred people," and total population levels in Wisconsin's pre-statehood history have been estimated to have been between 3,000 and 25,000.[23] Despite the small population, the territory the tribe covered in the late 1700s and early 1800s was large, comprising the northwestern third of Wisconsin as well as much of Michigan's Upper Peninsula.[24] This situation changed drastically in the 19th century, however, due to population and governmental pressures. In 1836, Wisconsin became a territory, and the Anglo population levels expanded rapidly. While "the US population increased 51 percent" between 1836 and 1850, the population in Wisconsin increased 2,514 percent during the same period.[25] And, while the migration to Wisconsin for most Anglos typically ended in the southern part of the territory, that movement steadily crept into the north, encroaching on Ojibwe hunting and gathering grounds. The government supported this encroachment by treaty; during the years of the Indian Removal, the Ojibwe also "lost legal control" of their land. A treaty signed in 1837 allowed the Ojibwe to continue their hunting and gathering "during the pleasure of the President of the United States"; this treaty was modified in 1842, when it was decided

[23] Bieder, *Native American Communities in Wisconsin*, 31.

[24] Helen Hornbeck Tanner, ed., *Atlas of Great Lakes Indian History* (Norman: University of Oklahoma Press, 1986), map 13.

[25] Bieder, *Native American Communities in Wisconsin*, 154.

that the Ojibwe would remain "until required to remove by the President of the United States."[26]

In 1850, the government decided that it was time for the Ojibwe to move. That year's annuity payments for Ojibwe living along Lake Superior, the Indian Commission subagent announced, would be paid in Sandy Lake, Minnesota, so tribe members would have to travel to get their money. About 3,000 Ojibwe traveled to Sandy Lake in late fall, "a journey of almost 500 miles for some," to get their payments; the government agents timed the payments to coincide with the beginning of winter in order to persuade the Ojibwe to remain and avoid having to travel in the cold.[27] Most of the Ojibwe who made the trip, however, were men who had left their families behind in Wisconsin; the men made the return trip in early December to reunite with their families. Those who returned did not bring the promised annuities, and nearly 400 of them had died on the journey from epidemic disease and exposure.[28] In 1852, tribal leaders traveled to meet with President Fillmore, "where they laid out the list of Chippewa grievances and broken American promises, including … the events at Sandy Lake in 1850."[29] Fillmore yielded and ended the efforts at Ojibwe removal. The ultimate result of this debacle was the Treaty of 1854, which assigned the Ojibwe to four reservations in northern Wisconsin: Red Cliff, on the northernmost point of Wisconsin touching Lake Superior; Bad River, slightly to the southeast of Red Cliff but also close to Lake Superior; Lac du Flambeau, to

[26] Mark Wyman, *The Wisconsin Frontier*, 223.

[27] *Ibid*., 223-4.

[28] This represents "12 percent of the tribal roll, drawn heavily from the tribe's active adult males." *Ibid*.

[29] *Ibid*., 225.

the southeast of Bad River; and Lac Courte Oreilles, to the southwest of the other three.[30] Although the government had designated four geographically separate reservations, by custom, Ojibwe living in one area were closely related to those living in the other areas; cross-reservation marriages and moves were common and supported by the semiannual Midewiwin dances.

Thirty-three years later and only a year before Dr. Cox had his encounter with Neweosh and the broken leg, the government passed the General Allotment Act of 1887, which provided for the elimination of tribal ownership of reservation land, passing that ownership to individual tribe members.[31] Indian commission agents would administer the land, ensuring that the tribal landowners would not sell their portions to speculators and encouraging individual assimilation into American society and eventually leading to US citizenship. This assimilation took many forms, including boarding schools for the children and government-run model farms. It also included an Indian-agent doctor, one that was likely fresh out of medical school and who was gaining on-the-job training for a few months before opening his own practice in a more lucrative community. This practice engendered a high level of distrust among the Ojibwe. A tribe member from Bad River interviewed by Sister Macaria Murphy, of the Franciscan Sisters of Perpetual Adoration, as part of a 1935 WPA Indian Research Project asserted that the Ojibwe:

> did not recognize the efficiency of the health measures of the white doctors; and they believed that all doctors were merely experimenting on their fellow-tribes-men; that they were not interested in curing the Indians who fell within their care; and that when an Indian went to a hospital he was as good as dead, - coincidentally, very few did return.

[30] A fifth group of Ojibwe remained at Mole Lake, although the area was not a designated reservation.

[31] Also known as the Dawes Act.

> Generally, the doctor appointed as a government physician was an inexperienced young man, who stayed just long enough to confirm the Indians' opinion that he came to the reservation for the sole purpose of acquiring experience, for his connection with the reservation was usually of very short duration.[32]

The General Allotment Act and the Treaty of 1854 had two other consequences that resulted in major economic disruption of Ojibwe tribal life. First, the reservation system ensured the restriction of the semi-nomadic lifestyle that supported Ojibwe cultural and trading practices. Access to traditional sources of blueberries, wild rice, and maple sugar was limited to reservation lands as was access to deer and fish. Because the land and weather in northern Wisconsin were not suited toward the type of agriculture that the government-run model farms were trying to teach, the amount of food that was available to the Ojibwe on the reservations was seriously constrained. The second consequence of the Allotment Act and the Treaty of 1854 was an increased ability for logging interests to make deals with individual Ojibwe for the lumber on individual land allotments. No longer was a treaty necessary for a lumber company to clear-cut a tract of land; after a short negotiation, the lumber company now paid an individual a set amount for the lumber and in return owned the trees outright. Not surprisingly, this situation left the door open to corruption and fraud, despite the presence of the Indian commission agents who were supposed to protect individual Ojibwe interests. The result of years of continued government oppression and increasing exploitation by their European-American neighbors caused the Ojibwe to strengthen their commitment to cultural and

[32] Marie D. Livingston, "Why do Indians object to have their dead taken to the morgue?" in *WPA Indian Research Project Collection, 1936-1940*, ed. Macaria Murphy (Milwaukee: Marquette University Department of Special Collections and University Archives, 1983). The Franciscan Sisters of Perpetual Adoration was headquartered in LaCrosse, Wisconsin.

social traditions instead of welcoming assimilation efforts. Midewiwin practices and ceremonies, as well as the dances and cross-reservation celebrations persisted and expanded well into the 20th century.[33]

Compared to the government agents' rather awkward attempts to promote assimilation of the Ojibwe into American society, the work being done in the area by the Catholic Church was flourishing at the end of the 19th century.[34] The Jesuits had entered northern Wisconsin in the late 1600s, where they did missionary work and acted as doctors, serving both the body and the soul and thus providing a holistic system of religious health care that mirrored the Ojibwe's Midewiwin practices. When the Jesuits left, the Franciscans arrived; as the new religious order was dedicated to service, the new missionaries continued the rudimentary health care work in which the Jesuits had engaged.[35] Thus, the Franciscans' practices meshed nicely with traditional Midewiwin practices; the priests provided what was clearly a religious world view and accompanied their preaching with a clear intent to heal the sick. The Ojibwe that were the target of the missionary work accepted the transition relatively seamlessly. One of the Franciscans who worked in the area noted that he was kept "busy, day and night, attending their sick-calls. It seemed strange to me that there should be so many people sick."[36] The Ojibwe

[33] Mark Wyman, *The Wisconsin Frontier*, 236-7.

[34] For general Church history, see: *Catholicism in America*, ed. Philip Gleason (New York: Harper & Row, 1970); Thomas Bokenkotter, *A Concise History of the Catholic Church*, Rev. and expanded ed. (Garden City, NY: Doubleday, 2004); Jay P. Dolan, *The American Catholic Experience: A History from Colonial Times to the Present* (Garden City, NY: Doubleday, 1985); James Hennessey, S.J., *American Catholics* (New York: Oxford University Press, 1983); and Bruce L. Shelley, *Church History in Plain Language*, Updated 2nd ed. (Nashville: Thomas Nelson Publishers, 1995).

[35] Shelley, *Church History*, 213.

[36] Verwyst, "Ideas and Experiences of a Missionary," 35.

who sought this missionary's health care efforts did so, however, with the cultural understanding that health and a religious worldview were one and the same. The people that the missionary was treating were most likely "restoring and prolonging" their lives while reinforcing their connections with this new community member, whom they understood to be a higher order practitioner.

The particular order of Franciscans that worked on the LCO reservation, the Franciscan Friary of St. Anthony of Padua, Province of the Sacred Heart, had established its headquarters in St. Louis, Missouri in 1858. Twenty years later, the order sent representatives to the area that had been targeted by Father Claude Jean Allouez in the 1600s and Father Baraga in the 1830s. The Sacred Heart Franciscans founded Holy Family Church in Bayfield, Wisconsin, from which a number of brothers and priests made early excursions into LCO territory. In the late 1870s, the Bayfield priests celebrated mass in the homes of Louis Corbine, a descendant of the French Canadian John Corbine who had migrated to the LCO area in the late 1700s, and Frank Oshoga, a descendant of one of the tribal leaders who had approached President Fillmore in 1852 regarding the Sandy Lake incident. In 1881, the OIA authorized the establishment of a 10-acre tract of land on the reservation that would be dedicated to Catholic mission work. The priests given charge of the mission in the early years included Casimir Vogt, OFM, a Dutch immigrant, and Chrysostom Verwyst, OFM, another Dutch immigrant, both of whom worked tirelessly to learn the Chippewa language. In those efforts to learn the language, the missionaries only reinforced the cultural and social ties that were created

through religious practices and rudimentary health care.[37] Recognizing the need to provide religious instruction to the children on the reservation, the friars began traveling among the logging camps in the area in 1885, gathering donations from both "whites and Indians" to build a "school and sister house"; the missionaries completed construction on both buildings that year. The new institution was to be staffed by an order of nuns whose motherhouse was in New Cassel, Wisconsin, a small town about 40 miles north of Milwaukee.[38]

These nuns, the School Sisters of St. Francis, had in their origins and in their customs practices that would make them ideal members of the LCO community. Originally from Schwarzach, Germany, a small town near Strasbourg, a small group of sisters ran an orphanage there, educating the children and nursing them when they were ill, in particular, during a terrible typhoid fever epidemic in 1869.[39] Following the War of 1870 and the German unification, Bismarck and the new German government passed a series of repressive pieces of legislation against the Catholic Church. During this *Kulturkampf*, a war for "truth, justice, and order," Bismarck attempted to assert the authority of the civil government over the church, which insisted, to Bismarck's consternation, that the Pope, Pius IX, was its authority.[40] In July 1872, the Reichstag

[37] Fowler, "Centennial Celebration of St. Francis Solanus Mission and School," St. Joseph Convent Archives; Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24.

[38] *Ibid.*

[39] Sister M. Francis Borgia, OSF, *He Sent Two: The Story of the Beginning of the School Sisters of St. Francis* (Milwaukee: The Bruce Publishing Company, 1965), 19.

[40] For more about the *Kulturkampf*, see Bokenkotter, *A Concise History*, 317-27.

expelled all Jesuits and affiliated orders, arguing that they had primary allegiance to Rome instead of to the German government.

As an affiliated order, the sisters at the orphanage were presented with a choice: they could return to their homes, leave the country, or remain and take care of the orphans but without their vows.[41] The majority of the women remained at the orphanage without their vows, but three nuns, Sister Alexia, Sister Alfons, and Sister Clara, decided to maintain their vows and leave the country. Later, Sister Alexia claimed that the three women decided to leave because they feared the *Kulturkampf*; there is some evidence that the three women left to follow their own path because Alexia's vision of the nuns' social role was wider than the vision that belonged to their directing priest. That priest, in particular, had been happy confining his – and the sisters' – work to the orphanage, while Alexia felt that the sisters should expand their congregation and develop a global focus. "Not wishing to convey an unfavorable impression" of the priest, Sister Alexia laid the responsibility for the move on Bismarck's policies.[42]

The three sisters landed in New York in late summer, 1873, and then traveled by train to Philadelphia, Chicago, and eventually Wisconsin, where they agreed to begin a school in New Cassel. Within a year of their immigration, the sisters had their school teaching the children of German immigrants, and they had the beginnings of the new order. The school was immediately successful; the sisters taught a "simple" course of studies, including "religious instruction, German reading, grammar and composition,

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[41] Borgia, *He Sent Two*, 27.

[42] Sister Jo Ann Euper, OSF, *1st Century of Service: The School Sisters of St. Francis* (Milwaukee: Bulfin Printers, Inc., 1976), 4-9.

English reading, grammar and composition, arithmetic, and spelling" to "over eighty students of assorted ages and sizes" in a single classroom. The value of this education was dubious in the early years, as the nuns themselves were unable to communicate well in English. For the first several years, the order had to get additional help teaching English reading, grammar, and composition.[43] By 1876, the new order had expanded, according to Sadlier's *Catholic Directory*, to "4 professed Sisters, 3 novices, [and] 5 postulants," a mixture of German immigrants and Americans.[44] Additional groups of postulants emigrated from Germany in 1880, 1882, 1884, and 1889, and as the order grew larger, it became a more diverse group of women from Germany, Illinois, Minnesota, and Wisconsin.[45]

Mother Alexia's desire to establish a "worldwide Congregation" led her to open schools in "wide and distant" places, nearly always in rural areas.[46] This focus on rural areas had a distinct advantage: because of population limitations, it was unlikely that any rural schools would need to expand. Therefore, a new school could be opened as soon as two more teaching nuns were ready to be sent. As a bonus, rural areas were fertile fields of potential postulants.[47]

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[43] Borgia, *He Sent Two*, 62-4.

[44] Quoted in *Ibid*., 71.

[45] *Ibid*., 77-8.

[46] Euper, *1st Century of Service*, 9.

[47] See for comparison: Joan M. Jensen, *Loosening the Bonds: Mid-Atlantic Farm Women, 1750-1850* (New Haven: Yale University Press, 1986); and Nancy Grey Osterud, *The Bonds of Community: The Lives of Farm Women in Nineteenth-Century New York* (Ithaca: Cornell University Press, 1990).

Ever practical, Mother Alexia did not hesitate to open a new mission school when the opportunity presented itself; correspondingly, she did not hesitate to close those same missions when they encountered difficulties. The main reasons for closing a mission were: the sisters found they had a more pressing need in another location; the local pastor stopped paying the sisters the amount he had agreed to pay; or the pastor began interfering with the sisters' work. In other words, the order was stretching its finances and its ability to staff missions, but just as the three original sisters refused the orphanage priest's opposition to their ambition, the order was unwilling to accept opposition to its independence. Within 30 years, the order had "about 540 professed sisters and some 70 novices" who staffed missions throughout the American Midwest as well as New York and Europe. According to a history of the order, "of the American missions [Mother Alexia] opened, she closed nearly one-half, many within a few years of their opening"; clearly the order had been able to successfully maintain its independence, even without the support or direction of a priest.[48]

The convent's first mission to serve a population that was not Caucasian was St. Francis Solanus Mission School at Reserve, which was established in 1885 in the two tiny LCO buildings that the Bayfield Sacred Heart Franciscans had collected donations to build.[49] The school operated on government funding, a result of prodding by the Bureau of Catholic Indian Missions (BCIM).[50] The sisters received a total of $600, which was

[48] Euper, *1st Century of Service*, 10, 24-5.

[49] *Ibid*., 62; Borgia, *He Sent Two*, 97-8.

[50] Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24.

"expected to cover all the missions' expenses for the year."[51] Among those mission expenses were "school supplies, stove wood, [and] full meals at dinner for each child."[52] Despite the sisters' clearly demonstrated competence in establishing and running missions throughout the American Midwest, the Franciscan fathers did not decide that the sisters were capable of managing the small LCO mission until 1892. At that point, the priests "turned the financial management of said school to Sister Fabiola and her community, the Sisters to pay annually $300.00 to the missionaries to defray their expenses."[53] The rest of the government funding - $7.50 per quarter per child – would be spent on the mission itself. Enrollment at the school averaged about 60 children, but actual attendance ranged between 40 and 45 children; the $7.50 per child was based on attendance rather than enrollment.[54]

Typically, the School Sisters of St. Francis who were sent to a new mission had "minimal preparation." The women had responsibility for children in "grades one through eight," where they taught "basic reading, writing, arithmetic, religion, social studies, art and music," all subjects that were based on the education the sisters had received prior to joining the Congregation. In the rural missions, the sisters also taught some basic agriculture, which usually meant that they planted and tended kitchen gardens

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[51] Euper, *1st Century of Service*, 63; Barbarlie Stiefermann, OSF, *Stanislaus ... With Feet in the World: Historical Biography of Mother M. Stanislaus Hegner Superior General of the School Sisters of St. Francis 1930-1942* (Baltimore: Gateway Press, Inc., 1990), 162.; and Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24.

[52] *Ibid.*

[53] *Ibid.*

[54] *Ibid.* Subtracting the fathers' $300 "expenses," this left the sisters about $1,000 per year to feed, clothe, and educate the children as well as to cover their own living expenses.

with the help of the young students as well as the students' families. The missions were usually staffed by two teaching sisters, each of whom was responsible for four of the eight grades; in addition, they "served as principal, parish organist and choir director." An additional sister served as the homemaker; she "raised chickens and produce, did the housekeeping, purchasing and preparing and canning of food, took care of the laundry and church linens, did the sacristy work and baked hosts."[55]

Despite the sisters' struggles with the English language in New Cassel, they taught the LCO Ojibwe mission children "all the common school" subjects, including English.[56] In addition, they taught the "girls all kind of fancy needle work besides the common mending & sewing," all in the school building, which was only 40 x 25 ft and 14 ft high.[57] A description of the mission school written by Sister Sirilla LaRush, who had grown up on the reservation and who was the order's "first Indian Sister," indicates that operations there followed the School Sisters' mission model closely. The sisters "made a garden for themselves so that they may have vegetables, … [and] had a cow named Lily so they had their own milk and made their own butter. They also taught the Indians how to … take care of a cow so that they could have milk for themselves and

[55] Euper, *1st Century of Service*, 11, 25-6.

[56]Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24. Among the first sisters who went to the LCO mission was Sister Aloysia Stallkampf, one of the order's German novices from the order's first reception class in July, 1875. See Euper, *1st Century of Service*, 63 and Borgia, *He Sent Two*, 65-6. One can only imagine the confusion among the Ojibwe living on the mission – they spoke Ojibwe; their priests spoke Dutch in secular settings and Latin during church services; their nuns spoke German and tried to teach them English, although few of the nuns spoke that language; and their neighbors spoke, variously, English, Norwegian, and Swedish.

[57] Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1-1, reel 24.

their children."[58] Deviating from the mission model only slightly, the sisters made the "boys do most all the garden work."[59]

The sisters and their activities fit nicely into the Ojibwe social system that was based on reciprocal relationships. The sisters shared their knowledge and skills and were the recipients of community care. On one occasion, in the "bitter cold" of winter, an Ojibwe came to the mission, asking if he could "warm himself" by the stove. The housekeeping sister "invited him into her kitchen," where the man "sat by the stove for a while" and then "opened the oven door" to enjoy more direct and intense heat. This would likely have been quite an intrusion, as the sister was probably alone and had certainly taken vows of chastity; this man was an adult who had taken no corresponding vows. Given the sisters' duties and chores, it was also likely that the homemaking sister was baking in that hot oven, so the loss of heat caused by an open oven door would have severely disrupted the homemaker's schedule. After the man had "warmed up he thanked the Sister and left." Following the requirements of a reciprocal relationship, the man returned a few days later "and brought Sister a big deer leg." On other occasions, "the Indians would also bring the Sisters nice fresh fish" and "berries in season."[60]

This reciprocal relationship the sisters enjoyed with the LCO Ojibwe deepened over the first decade of the mission school's existence, thus creating some dedicated friends as well as persistent enemies. One enemy, the government agent living on the reservation, "Farmer" Morgan was typical of Indian agents in the late 1800s. The

[58] Borgia, *He Sent Two*, 97; "Fabiola (Sister Sirilla) LaRush," St. Joseph Convent Archives, 3-4.

[59] Sr. M. Fabiola, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24.

[60] "Fabiola (Sister Sirilla) LaRush," 4-5.

government farmer was supposed to take care of the Indians living on his reservation by, among other activities, "depositing their off-reservation earnings in a bank and doling out weekly allowances, helping them through tough times by allowing them to work for food and clothing, having land cleared to enable them to farm, all the while cheering them on or condemning their laziness."[61] In reality, however, the situation was one that was ripe for graft. When lumber contracts on the LCO were sold in 1872, the price that individual Ojibwe received was well below market value, a situation, it was argued 30 years later by the Indian Rights Association, likely due to "collusion" between the lumber company that bought the contract and the government farmer.[62] Deposits and withdrawals at the off-reservation banks were not always accurate, and even government allotments sometimes mysteriously went missing.

In late 1889, Farmer Morgan's daughter decided to open a school of her own on the LCO reservation; she was entering into a direct struggle with the sisters for the $7.50 per quarter per child that the government was willing to pay. Morgan, in an attempt to help his daughter gain students, sent word to the tribe members that they should send their children to his school "if expecting to get any allotments" that were due to the children. If the tribe members refused, Morgan "would refuse the allotments and make [the Indians] prove where the children [were] born, outside or inside the Reserve," a condition crucial to the government allotment system. Tribe members Ira Isham, Jr. and John LaRuth refused to play the farmer's game. Instead, they made formal complaints to the Office of Indian Affairs (OIA), with the assistance of the Franciscan friars and the

[61] Wyman, *The Wisconsin Frontier*, 228.

[62] Bieder, *Native American Communities in Wisconsin*, 169.

BCIM, arguing that they "had been well satisfied with the schooling [the children] receive at present in our Sisters School."[63]

The following spring, Farmer Morgan made another attempt to close the sisters' school. An OIA agent visited the LCO reservation for an inspection and then returned to his office to file a report critical of the school. The Commissioner of Indian Affairs wrote to Father J.A. Stephan, Director of the BCIM, asking him to investigate the criticisms, as it was the BCIM that had originally prompted the OIA to pay for the school. Father Vogt, responding to Stephan's enquiries, declared that he was not surprised that the OIA agent had been critical, as "his judgment" was "probably influced" [sic] by the farmer. One criticism, in particular, was directed at Sister Angelina and her qualifications for the job. Fr. Vogt noted that the sister was "a splendid teacher" who "manages the school in a most gentle way but with the greatest energy." However, in deference to the BCIM and OIA, and to deflect some of the criticisms, Fr. Vogt persuaded Angelina to leave, and she was replaced with another "able teacher," Sister Fabiola.[64]

By spring 1891, the complaints the LCO Ojibwe had made about Farmer Morgan in 1889 finally made their way back to the reservation. Another OIA agent, Mr. Leahy, visited the reservation, officially in order to investigate the complaints further. Unofficially, Leahy "reprimanded most severely the poor Indians for having made said

[63] Vogt to Rt. Rev. Bishop Mantin Marty, D.D., Sioux Falls, SD, 4 March 1891, including transcriptions of affadavits: John King and Gust Thomas, 11 November 1889; John Laruth, 11 November 1889; Ira Isham, 11 November 1889; Frank Thomas, 11 November 1889; Thos. Russel, 6 February 1891; Minogijigokwa, 8 February 1891; Pahkwawong, 8 February 1891; Babokoway, 20 February 1891; and Chas. Patrick 23 February 1891, *BCIM General Correspondence*, ser. 1-1, reel 23.

[64] Stephan to Vogt, 21 July 1890; Vogt to Stephan, 29 July 1890; Vogt to Stephan, 4 September 1890, *BCIM General Correspondence*, ser. 1-1, reel 22.

complaint." By this point, word had gotten to Hayward that there was a growing controversy on the reservation, and three Haywardites came to the school for their own visit. The visitors included R.L. McCormick, President of the NWLC, and Rev. JW Heyward, pastor of Hayward's Congregational Church. After their visit, the three reported that they were "well satisfied" with the school, and "Mr. McCormick gave at Hayward publicly great praise to [the] Sisters and credit to [the] school being far advanced above" similar schools.[65] Compared to Hayward's school, however, the mission school was far from being "far advanced" academically. The mission children were learning how to sew and take care of cows and gardens, but they were not learning how to read. The sisters' problems with the English language and their focus on religious instruction ensured that the children they had instructed were far below the educational level they ought to have been; the difference in education was so notable that educators at the Hayward Indian School made special note about the deficiencies a decade later.[66] The visitors' support of the sisters and the mission school makes more sense when one considers that the government farmer was causing troubles in Hayward, and the Ojibwe had clearly embraced the sisters as being part of the permanent LCO community.

A critical element in this relationship was the sisters' work in health care, which the Ojibwe integrated into their own religious and therapeutic worldview. The sisters, as an order, had brought with them a tradition of lay health care when they had originally immigrated. This tradition was fortified and expanded in the early 1890s by actions

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[65] Vogt to Stephan, 15 April 1891, *BCIM General Correspondence*, ser. 1-1, reel 23.

[66]"Narrative Reports: Hayward Training School for year ending June 30, 1917" in *United States OIA*; C.M. Knight, Inspector, "Report on the Lac Courte Oreilles Reservation and the Hayward Indian Training School," (September 24, 1918), 1-3, "Statistical Reports" in *United States OIA*.

taken by the mother superior. In 1887, only a few years after they had agreed to open the LCO mission school, the sisters moved their motherhouse from New Cassel to an area that eventually became part of Milwaukee, and they built a beautiful, although poorly constructed, new convent. Three years later, the newly built convent burned to the ground, and one of the sisters died of injuries she sustained when she jumped from an attic window. The motherhouse was rebuilt, but for Mother Alexia, the stress involved in the tragedy led to the development of a chronic case of bronchitis. As the *Kulturkampf* had ended, Alexia chose to return to Bavaria with a companion, Sister Hyacinth Gremminger, in May 1892, to seek treatment and recuperation.[67] During her convalescence at Wörishofen, "the world-famous hydrotherapy center," Alexia became enamored with a course of water cure treatments advocated by Monsignor Sebastian Kneipp, who wrote *Meine Wasserkur* in 1882 (translated as *My Water-Cure* in 1891).[68] Kneipp promoted his hydrotherapy philosophy, practices, and books so successfully that *My Water-Cure* was still in publication a hundred years later. Nevertheless, he "preferred his role as a priest to that of 'doctor,'" a separation of religious and health-based identities that would have been impossible for Midewiwin practitioners.[69]

The Kneipp method was a variation of the older system of hydrotherapy, which had also developed in Europe. And, hydrotherapy was a variation of a much older and more traditional European medical treatment. In the 17th and 18th centuries, European patients, who had the necessary financial resources, often took "water" therapy as a

[67] Borgia, *He Sent Two*, 107, 112-21.

[68] Borgia, *He Sent Two*, 131-3; and Stiefermann, *Stanislaus ... With Feet in the World*, 49. For more on the Kneipp cure, see Whorton, *Nature Cures*, 192.

[69] Stiefermann, *Stanislaus ... With Feet in the World*, 50.

supplement to the predictable bleeding and purging that their physicians prescribed. As James C. Whorton points out in *Nature Cures*, this "spa therapy," which was "presumed to be of some value for just about any ailment, … was strongly recommended for only a small number of conditions," including "rheumatism, gout, and bladder stones." A patient who was "taking the waters" would drink and bathe in mineral springs at resort towns that supplied both the water and the entertainment that the patient desired.[70]

In 1829, an Austrian named Vincent Priessnitz enhanced this resort therapy with a series of treatments that he called hydropathy. Hydropathy was much more rigorous than the "taking of the waters." For one, the patient no longer enjoyed warm baths but spent his time dipping in cold water and taking cold, sometimes freezing, showers. And after his bath, the patient no longer had the time or energy to enjoy a concert or a gambling table. Instead, the patient endured a demanding schedule of baths and walks, alternating with periods in which he would drink large quantities of cold water and would be wrapped in wet bandages; this treatment could last all day.[71]

What value hydrotherapy had is dubious. Priessnitz claimed that that the cold water was able to mitigate inflammation while it stirred the "body systems." More importantly, Priessnitz believed that sickness was caused by poisons contaminating the body and the cold water would "dissolve these malefic particles and carry them to the skin, where they could be sweated and washed away through pores opened by the stimulus of the cold baths." American practitioners who embraced hydropathy connected this vague theory of "malefic particles" to their understanding that the body produced its

[70] Whorton, *Nature Cures*, 77-78.

[71] *Ibid*., 78-80.

own poisons - wastes that needed to be eliminated. When the body was no longer able to eliminate its own wastes, American hydropaths used their treatment to sweat the wastes from the patient's pores, as opposed to plaster doctors like Till, who would burn the wastes away. Cold water was, in effect, a cleanser that eliminated the old in order to make room for the body's production of the new.[72]

Hydropathy had been practiced in Europe for nearly twenty years when the young priest Sebastian Kneipp turned to it in order to recover his health. Kneipp had spent too much time studying and was, as a consequence, very ill when he began taking – and was restored to health by - the water cure.[73] When he was assigned to the parish at Wörishofen, he developed and elaborated on the standard hydrotherapy treatments and established his own spa. His books became bestsellers, and his treatment, the "Kneipp method," was adopted by "Kneipp spas [that] sprang up throughout Germany and in neighboring countries."[74] As he had published his theories in books that continued to remain in print for many years, the therapy he promoted became significantly more egalitarian than original spa therapies or even hydropathy. Patients no longer needed considerable financial resources to attempt a water cure; they only needed to be able to read and understand the Kneipp method.

The Kneipp method employed the same cold-water baths and wraps that Priessnitz had advocated. It also used warm, hot, and steam baths, sometimes seasoned with botanicals. Patients at a Kneipp spa drank water, as they would have done at a

[72] *Ibid*., 81-3.

[73] Kneipp, *My Water Cure*, 2.

[74] Whorton, *Nature Cures*, 192.

hydrotherapy center, but that water might contain herbs and botanical extracts. And, while hydrotherapy patients were instructed to talk long, brisk walks, Kneipp patients were taught to take those walks barefoot, especially "in snow, when available, or else over wet grass." (Fig. 3.6) This prescription stemmed from Kneipp's belief that the poisons that needed to be expelled would have naturally been eliminated from the body, had progress not tempered society. Patients were, in effect, "soft" and needed to be hardened in order to restore their "primitive vigor." Adherents to the Kneipp method were advised that "even infants were to be given a quick cold water dip every morning to forestall effeminacy."[75]

As a headstrong woman who typically jumped into projects with both feet, Mother Alexia decided that Milwaukee needed a sanitarium that provided the Kneipp "water-cure" and that the School Sisters of St. Francis would be the ones to run that institution. While Milwaukee certainly may have needed another health care establishment, Alexia's decision was probably influenced by the congregation's ever-present financial needs; after all, a health spa "would attract wealthier people and provide the income needed to sustain the schools," like the one on LCO, which still struggled seven full years after its establishment.[76] Sister Hyacinth immediately began to study "methods of water cures and massaging" in preparation for the new venture.[77] Alexia and Hyacinth returned to the United States in the fall of 1892, began construction on the

[75] *Ibid*., 191-2.

[76] Euper, *1st Century of Service*, 40.

[77] Stiefermann, *Stanislaus ... With Feet in the World*, 50.

sanitarium the next spring, and hired "Dr. I.L. Hirschfield of Baden to train the sisters."[78] Sacred Heart Sanitarium, built next to the convent on lots that cost the sisters $8,000 in 1893, was completed within a year. (Figs. 3.3-3.5) Even before it was finished, the sisters had already begun taking patients, treating them "on the first floor of the motherhouse."[79] Sacred Heart had to close the first year it was opened, as there was a serious smallpox epidemic in the area that winter, but it soon reopened, eventually becoming a thriving establishment.

Early sanitarium treatments followed Monsignor Kneipp's method closely, but before long, the sisters expanded their offerings. A description of the sanitarium in 1903 confirms the institution's success; besides the "medicated air baths," patients could take advantage of:

> A free billiard room; bowling alley; assembly parlor with a piano; lawn tennis courts; a recreation hall, 25 x 100 feet, for handball, basketball, exercises and medical gymnastics; a parlor for sun baths, 12 x 100 feet, roofed over with different colored glass. The basement, 50 x 220 feet, is devoted to baths, there being fifty kinds of water applications, every variety of electrical treatments, scientific massage and sixty Zander machines for giving the Swedish Movement Cure, the latter representing an investment of nearly $210,000. The baths embrace many varieties, among them being sulphur, carbonic acid, the Italian mud baths, importing the mud from Italy at a cost of forty dollars per barrel, Wickels Hay Flower and other special ones.[80]

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[78] Euper, *1st Century of Service*, 40.

[79] Borgia, *He Sent Two*, 131-3; and Stiefermann, *Stanislaus ... With Feet in the World*, 51. This was at a time in which the sisters stationed at the LCO mission were receiving less than $1,000 a year to teach 60 students and run the entire operation.

[80] Stiefermann, *Stanislaus ... With Feet in the World* , quoting from *A Monthly Magazine for the Housekeeper*, 51-52.

By 1912, the sanitarium was also providing "Brine Baths, Electric Light Applications, … and numerous other herb and medicated water appliances."[81] Also in 1912, the sisters began to train for, and pass, the state pharmacist registration exams. That same year, the sisters opened a 100-bed establishment, St. Mary's Hill, which was dedicated to the treatment of the mentally ill.[82] This new enterprise continued the general focus of the sanitarium, giving more water treatments and providing care that was sensitive compared to typical contemporary treatment of the mentally ill.[83] "Chief" among these water treatments was the sisters' version of hydrotherapy, which consisted of "thousands of wet-sheet packs, continuous tub baths and salt glows [which] meant thousands of work hours."[84] By 1928, the Sanitarium alone "had 350 beds and was equipped with every facility for the most up-to-date diagnostic and therapeutic service."[85]

Although the sisters had been trained by Dr. Hirschfield in water-cure treatments when Sacred Heart first opened, most of the sisters learned their health care on-the-job. Sisters who trained as nurses "began without special training and learned as they worked, using whatever resources were available to them." That training became formalized in 1915, when Mother Alfons "directed Sister Patricia, a professional nurse, to open a

[81] Borgia, *He Sent Two,* 170.

[82] Euper, *1st Century of Service*, 40-1.

[83] This "care," according to Euper, was "expressed more in terms of humaneness than of medical knowledge and therapeutic skills. 'Care' was chiefly custodial, and it could be very crude." *Ibid*., 41.

[84] Borgia, *He Sent Two*, 171.

[85] *Ibid*., 131-3; and Euper, *1st Century of Service*, 40.

school of nursing at the Sanitarium, in cooperation with the doctors."[86] This doctor-directed, on-the-job training was legal, as state law did not yet require nurse licensing.

The sisters briefly became involved in some hospital work in Galena, Illinois in the first decade of the 1900s, but essentially, Sacred Heart Sanitarium and St. Mary's Hill psychiatric center remained the sisters' only formal health care institutions until 1938.[87] This does not mean, however, that the sisters who did mission and school work did not become involved in health care. Euper points out that the mission work at Reserve included "teaching, catechizing and some amount of health work," as was typical of the sisters' work elsewhere. Because "there were no doctors or clinics … [and] there were chronic shortages of supplies and much illness exacerbated by harsh climates and environments" at the Reserve, as well as at many of the sisters' other missions, it is likely that the sisters would have continued the water therapy they had been trained to do when confronted with a situation requiring health care.[88] And, since the staff at the LCO school was constantly changing, sisters who learned hydrotherapy after Sacred Heart Sanitarium was built would have brought that knowledge to the LCO. (Table 3)

From the Ojibwe perspective, the water therapy that the sisters used was a natural extension of Midewiwin practices. A Midewiwin cure for a headache, for example,

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[86] Euper, *1st Century of Service*, 42.

[87] *Ibid*., 42. Legal requirements changed in 1921, when the Sheppard-Towner Act prompted the Wisconsin State Board of Health to take responsibility for nurse training. Unaware of the developments in the regulation of nurse training, the Sanitarium continued its school of nursing as before until 1924, when "there was an epidemic of smallpox and diphtheria." The Milwaukee Health Department investigated the Sanitarium when it was reported that several of the sisters fell victim to the epidemic. Further investigations revealed that none of the nurses who worked at the Sanitarium were registered with the state, and the discrepancy between state regulations and the existing situation was quickly remedied. Euper, 43.

[88] *Ibid*., 62.

might include a tea, to be drunk by the sufferer, made of boiled and crushed leaves of the tamarack.[89] A Kneipp cure for a headache might also include a simple tea made of crushed rose or goldenrod.[90] If the headache continued, a Midewiwin practitioner might apply a poultice of tamarack leaves and bark to the sufferer's forehead, while the Kneipp therapist might prescribe a honey or hayflower poultice. The Midewiwin patient might also be sweated with a tamarack steam, while the Kneipp patient might be given an herbal vapor. And, Midewiwin patients would also be given lengthy herbal baths to wash away the bad spirits causing the headache, while Kneipp patients would endure cold water applications to harden the body and prevent future headaches. While the Midewiwin therapist worked, he or she might speak to Mide Manido, just as the sister would pray for her patient's soul.

Despite the order's astounding success at building and operating the sanitarium and St. Mary's Hill, the sisters experienced chronic money problems at the mission. The construction of the LCO mission had been originally fully funded through donations, but the mission's continued operations depended on government funding and on BCIM support for that funding. And while the funding was based on attendance levels at the mission school, the money the sisters received paid for materials that did not necessarily decrease with lowered attendance levels. The funding paid for teacher salaries, books and supplies, wood for the stove, and a daily lunch for the children and sometimes for

[89] Walter James Hoffman, *The Mide'wiwin*, 198.

[90] Kneipp, *My Water-Cure.*

their families.[91] Money was always tight; thus, the future of the mission was continually in doubt. At first, there was confusion regarding the difference between enrollment and attendance. The sisters budgeted their activities based on enrollment, and when they received their first payments, they were surprised that the critical number was attendance, figured down to the fraction of a person. Further, there was no "rounding up" in that fraction. In December 1886, for example, the sisters requested money for an average daily attendance of 45; what they received was recalculated for an average daily attendance of 44 and a fraction slightly over ½.[92] As early as 1890, the Bayfield mission priests began sending appeals to the BCIM, begging for more funding, as the children had to receive more meals than were originally thought.[93] All requests were denied.

By 1902, the situation had become critical. The government had built an Indian Boarding School in Hayward, and many LCO parents were sending their children there, in part because the boarding school would provide food, clothing, and room and board, all of which were increasingly difficult to provide on the limited reservation system. The mission school was not only losing students; all funding for the mission school would be cut off until the Hayward school was filled. With their funding in doubt, the sisters briefly left the LCO, but they ultimately continued their mission on faith that the

[91] Chrysostom Verwyst, "Brief History of the Catholic Mission of Courtes Oreilles, Wis." *BCIM General Correspondence*, ser. 1, reel 24.

[92] Exchanges between Bayfield fathers and Stephen, *BCIM General Correspondence*, ser. 1-1, reel 16.

[93] Exchanges between Bayfield Fathers and Stephen, *BCIM General Correspondence*, ser. 1-1, reel 22.

government would restore the funding, or at the very least, the BCIM would produce funding on its own.[94]

In 1908, the St. Louis Province of the Sacred Heart, which was in charge of the Bayfield mission, recalled Father Agatho, the priest who had been in charge of the LCO mission. Father Agatho had been working on the LCO for many years and, by that time, had learned the Ojibwe language and become an accepted member of the community. Father Agatho's replacement, in comparison, was much less than satisfactory. He attempted to learn Ojibwe but had been a missionary among the Menominee for many years and so mixed the two languages together; the LCO Ojibwe could "hardly" understand him.[95] Not understanding the complex relationship in and the hierarchy of the Catholic church, the LCO Ojibwe assumed that the St. Louis "fathers" also could recall the sisters; the fact that the sisters had left in 1902 for a few months only reinforced the fear among the Ojibwe that they would lose their trusted friends and allies.

As it turned out, this fear was well founded. The motherhouse in Milwaukee had recently experienced a minor epidemic, and many of the sisters there had died or remained ill. The mother superior was also ill, and she wrote to the LCO sisters, asking them to return to Milwaukee to help. The fact that the sisters' funding at LCO was less than adequate only supported the recall.[96] The priests at Bayfield and St. Louis were thrown into a panic when they received the sisters' resignation, and they began a letter writing campaign to bring the sisters back to LCO. Between themselves, the BCIM,

[94] Exchanges between Bayfield Fathers and Ketcham, *BCIM General Correspondence*, ser. 1-1, reels 42, 45.

[95] Exchanges between Bayfield Fathers and Ketcham, *BCIM General Correspondence*, ser. 1-1, reel 43.

[96] Sisters of St. Francis to Ketcham, 25 October 1908, *BCIM General Correspondence*, ser. 1-1, reel 43.

Bayfield, and St. Louis priests decided that the sisters had really left because they were infatuated with Father Agatho and that they had, indeed, received enough funding all along.[97] The sisters were, in short, troublesome, irrational, and uncontrollable, and the priests doubted that the women could make wise decisions based on sense and logic. As the BCIM director wrote to the Very Rev. Cyprian Banschied, OFM of the St. Louis Province:

> We had a somewhat similar experience some years ago and were put to all kinds of trouble to remedy the situation, trouble that was entirely unnecessary had the Sisters perservered in their work and not given it up. It is this inconstancy on the part of our teachers enjoying Government positions that renders it practically impossible to avail ourselves of any Government help whatever on Indian Reservations. On account of this we have lost a number of schools. Sisters get into a panic and, regardless of good advice, surrender everything, then repent at leisure and of course we have to bear the brunt of the whole situation.[98]

Despite the priests' attempted persuasions, the School Sisters of St. Francis decided not to return to the LCO mission - a mission that they had themselves decided represented a troublesome, irrational, and uncontrollable situation. The sisters had the business sense to know that the mission was not good business, and they were independent enough to resent being treated as if they were insensible and illogical. Despite their strong affinity with the Ojibwe, the people they had educated and nursed for over twenty years, the sisters resolved to move on to other missions, where they would experience more freedom to operate their affairs as they saw fit instead of being accountable to a committee of men in remote places like St. Louis and Washington DC.

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[97] Exchange between Fr. Banscheid, OFM and Fr. Ketcham, October-November, 1908, *BCIM General Correspondence*, ser. 1-1, reel 43.

[98] Ketcham to Very Rev. Cyprian Banschied, OFM, Provincial, St. Louis, 16 October 1908, *BCIM General Correspondence*, ser. 1-1, reel 43.

In order to keep the LCO mission running, the Bayfield priests resorted to a new, geographically closer – and theoretically easier to control - order of nuns, the Sisters of St. Joseph out of Superior, Wisconsin. These new sisters reopened the LCO mission school in 1909, but attendance had dropped well below the average daily attendance in the late 1800s of 44 and a slight fraction over ½.[99] LCO Ojibwe had sent their children to the newly opened Hayward government school instead of waiting for the mission school to reopen. Because the mission school had closed and reopened several times since 1904, and since the LCO Ojibwe knew that the School Sisters of St. Francis had definitely left, they had substantial doubt that the school would reopen at all.

The Sisters of St. Joseph, who were part of a small, newly founded order and who were inexperienced in ventures of this sort, soon found that they had their own problems with funding, and they supplemented that funding by hiring themselves out as teachers to the Hayward boarding school. After a full seven years at the mission school, the Sisters of St. Joseph complained that they had to begin boarding students in order to keep them, as the Ojibwe parents expected the same level of service from the mission school that they would have gotten from the Hayward government school. For these parents, it was no longer enough that the sisters and their activities merge into the tribe's customs and the Ojibwe's traditional worldviews. The Ojibwe worldview was, in fact, beginning to change. The tribe's culture had been, historically, very flexible, in part to modify conditions of their semi-nomadic migrations. This situation was little different. The tribe's children were migrating to receive their education, and in the course of that migration, the children and their families began to expect food, clothing, and room and

[99] Exchange between Bayfield Fathers and Ketcham, *BCIM General Correspondence*, ser. 1-1, reel 47.

board. The government and the BCIM, however, were unwilling to meet funding requirements that would allow for this level of service at the mission school boarding, and so the agencies had only continued payments on a day school basis.[100]

The problems that the Bayfield mission and the St. Louis Province had in staffing the LCO with a priest that was acceptable to the congregation also continued. In late 1913, it appeared that a solution had arrived. A young Ojibwe from the Lac du Flambeau reservation, Ti-Bish-Ko-Gi-Jik had recently completed his education and had been ordained as Father Philip Gordon in Superior.[101] (Fig. 3.7) As an Ojibwe from a neighboring reservation, Fr. Gordon had a unique connection to the LCO. He spoke the language and understood tribal customs and rituals. He had also worked briefly, as a young man, at lumbering, first at a camp one winter where he "helped with scaling and tallying" and then at a mill. Fr. Gordon was also able to communicate effectively with his superiors in Bayfield, St. Louis, and even with the bureaucracy of the BCIM in Washington. He had traveled in Europe extensively and had attended American College in Rome for a year and the University of Innsbruck for two years. Moreover, he was fluent in English, French, German, Italian, and "numerous Indian dialects."[102]

In short, what the Bayfield mission and St. Louis province expected was an Indian priest who would be able to convert the unconverted and reduce the level of trouble that the reservation Indians caused. After all, there would be no confusion regarding the differences between the Ojibwe and Menominee languages, and Fr. Gordon certainly

[100] Ketcham to Sisters of St. Joseph, 6 December 1916, *BCIM General Correspondence*, ser. 1-1, reel 82.

[101] Paula Delfeld, *The Indian Priest: Father Philip B. Gordon, 1885-1948* (Chicago: Franciscan Herald Press, 1977), 17. Ti-Bish-Ko-Gi-Jik means "Looking into the Sky."

[102] *Ibid*., 39, 55.

understood tribal customs and expectations. Consequently, he would be more likely to effectively communicate the government's and BCIM's expectations to the Ojibwe, and as a "native son," would theoretically have been able to get the LCO Ojibwe to agree to those expectations. What the mission and the province got, however, was a priest who used his emerging fame and reputation to become an intense activist and promoter of Native American rights, not only for his fellow Ojibwe but also for Native Americans throughout the country. In 1915, Fr. Gordon joined the Society of American Indians, a "group of educated Indians working for justice" for Native Americans across the country; he later became president of that society.[103] As a member of the society, Fr. Gordon made close contact with the activist Dr. Carlos Montezuma, and he maintained that relationship for many years. (Fig. 3.8) And, when accused of being of bad character or of being a trouble maker, Fr. Gordon was not afraid to speak out, accusing the Office of Indian Affairs of labeling activist Indians as Bolsheviks. He argued:

> 'It is an old trick of the Indian Office to blacken the character of any Indian that happens, notwithstanding the retardation caused by the Indian Bureau, to rise a little above the ranks. So soon as an educated Indian begins to deplore the sad and vile condition of his brother Indians, the Indian Office dubs such a one as a disturber, an agitator, and lately he is placed in the Bolshevik class. The whole Indian Bureau system of managing Indian affairs, or rather of mismanaging Indian business to the detriment of the Indian but for the benefit of a few greedy and voracious whites, is the most dramatic autocracy in existence the world over.[104]

Even as he was being ordained, Fr. Gordon maintained his intimate connections to his tribe, despite the religious conflict that those connections could have created. At the

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[103] *Ibid*., 59.

[104] "Father Gordon Raps Indian Office: Indian Priest Charges U.S. Bureau With Tyrannizing Indians," *Catholic Tribune* (Dubuque, Iowa), 23 April 1920.

ordination, Ojibwe celebrants played the war drum and passed the peace pipe; this drum and pipe were given to Fr. Gordon, who promptly passed the items to his childhood best friend, who had become a Midewiwin chief at the LCO.[105] When Fr. Gordon was assigned to the LCO reservation, he began organizing dances and celebrations, complete with traditional feasts that were now to be paid for with church funds. He preached his activism from the pulpit, and he even "had Dr. Montezuma visit him during the celebration of Corpus Christi, that this man might pour forth his typical tirades against the Indian Service."[106] When visiting among the tribe, Fr. Gordon collected the "old complaints … against the Government, as to their allotments," and by the late 1910s, he had enough ammunition and power to begin waging an activist war over conditions at the LCO reservation.[107]

Fr. Gordon began writing letters to the BCIM, the OIA, and Wisconsin Sen. Lenroot; he also began writing letters to various newspapers throughout the country and even began publishing his own newspaper, the *Anishinabe Enamiad*, to extend the range and impact of his complaints. He asserted violations of reservation boundaries set in the Treaty of 1854, claimed that allotments were being arbitrarily cancelled, maintained that the Ojibwe were being unfairly restrained in their right to organize as a tribe, contended that logging operations were generally corrupt, and stated that the services that the

[105] Delfeld, *The Indian Priest*, 8.

[106] Exchanges between Bayfield Fathers and Ketcham, 3 June 1921, *BCIM General Correspondence*, ser. 1-1.

[107] Henry McQuigg to Ketcham, 5 September 1918, *BCIM General Correspondence*, ser. 1-1, reel 90.

Ojibwe were due, especially the medical service, were intolerably inadequate.[108] Specifically, regarding that last complaint, Fr. Gordon asserted that the physician serving the reservation was corrupt and not fulfilling his duties, that pharmaceuticals for the reservation were incomplete and inadequate, and that, most importantly, serious illnesses on the reservation were being ignored.[109] Fr. Gordon pointed out that at least ten children on the reservation had died in a three-month period, five within only three weeks, from what appeared to be polio. In addition, none of those children had been attended by the agency physician or any other doctor, except one child who was seen "accidentally" when the physician involved was checking the family for trachoma.[110] All of Fr. Gordon's complaints were discounted by an OIA investigator.

Fr. Gordon had a special talent for agitating the sisters who were in charge of the mission school. He asserted that they should confine their activities to education and that the level of education that they were providing was by no means adequate. He complained that "the teachers are incompetent; that six or eight Indian children are crowded into a little attic room not more than ten by eight feet; that boys and girls use the same toilet; that one teacher does not teach half the time; that there has never been any regular inspection of the school, etc."[111] His preferred solution was to bring the school up to Wisconsin state standards; the school should have been a regular, eight-grade

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[108] "Narrative Reports: Hayward Training School for year ending June 30, 1917" in *United States OIA*; C.M. Knight, Inspector, "Report on the Lac Courte Oreilles Reservation and the Hayward Indian Training School," (September 24, 1918), 1-3, "Statistical Reports" in *United States OIA*.

[109] *Ibid*., "Health and medical service."

[110] *Ibid*. Trachoma is a bacterial illness that can result in blindness. The OIA took special initiatives to combat the disease among Native Americans, a population in which the disease was endemic.

[111] *Ibid.*

school taught by teachers who had been formally trained at state normal schools.[112] There was some evidence that the sisters at the LCO mission were not good teachers. At least one who also taught at the Hayward Boarding School was evaluated in 1917 as a teacher who "lacks ability to plan her work, and has not natural ability as a teacher."[113] An OIA inspector disagreed that the mission school was substantially inferior to Wisconsin public schools. However, he maintained that it was critical to keep the peace on the reservation, where individual Ojibwe were beginning to take sides with either Fr. Gordon, who had assumed a leadership role within the tribe, or with the sisters, who taught and fed their children and took care of their sick. Therefore, the OIA inspector argued, the "government should withdraw its support" of the mission school, and Wisconsin should establish a public school system on the reservation.[114]

By 1919, the Sisters of St. Joseph decided, as had the School Sisters of St. Francis ten years earlier, that they had enough of this troublesome mission. They had worked at the LCO mission for a decade, providing education and room and board for many of the reservation children, and they had also worked among the adult Ojibwe. As there was no government physician or nurse who lived on the LCO and who was available at a moment's notice, the sisters had filled that role, providing "instruction … in health, sanitation, [and] morals" as well as acting as "Practical Nurses and Matrons" who taught

[112] Philip Gordon to Ketcham, 2 December 1918, *BCIM General Correspondence*, ser. 1-1, reel 90.

[113] W.W. Coon, Ass't Supervisor of Ind. Schools, "Report on Supervision of the Hayward Schools" (May 21-31, 1917), 9-10, "Statistical Reports" in *United States OIA*.

[114] Inspection report, *BCIM General Correspondence*, ser. 1-1, reel 98.

the Ojibwe women sewing and "home-making."[115] Yet Fr. Gordon, with the support of the Ojibwe who were now behind his campaign to modernize reservation management, informed the sisters that they were being evicted from the mission buildings.[116] The sisters quickly packed up their belongings as well as all of the furniture that was in mission school and prepared to leave.[117] As they prepared to evacuate, they "destroyed the adornments and beauties which had been erected through their efforts and work." They continued this path of destruction, contacting the husband of one of the LCO women, to whom they had given life-saving health care, and asking him to cut down the flagpole that they had erected several years earlier. When the Ojibwe refused to do this, they "took an axe and were going to cut it themselves" until the man decided to help them in their efforts.[118]

When this second order of Catholic sisters left the reservation, they completed the process that had begun when the School Sisters of St. Francis had left, over ten years earlier. Sisters in both orders had integrated into the community that they served, through the care and nurturing they gave to the children they taught and the Ojibwe they nursed. The health care they provided was multi-dimensional, and thus it had meshed well with traditional Midewiwin remedies and values. However, as time progressed and conditions on the LCO changed, the sisters' care became gradually less satisfactory to the Ojibwe.

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[115] "Narrative Reports: Hayward Training School for year ending June 30, 1914" in *United States Office of Indian Affairs* [hereafter *OIA*]; "Narrative Reports: Hayward Training School for year ending June 30, 1918" in *United States OIA.*

[116] Gordon to Mother M. Evangela, Supr., Sisters of St. Joseph, Superior, Wis, 11 November 1918, "Statistical Reports" in *United States OIA.*

[117] Inspection report, *BCIM General Correspondence*, ser. 1-1, reel 98.

[118] *Ibid.*

The School Sisters had offered teas, warm baths, and herbal remedies, as well as food, education, and religious instruction. LCO tribe members had rejected the abrupt and incomprehensible treatment that Dr. Cox had provided to the son of Shabogesic in 1888, but they had embraced the School Sisters' care. The Sisters of St. Joseph also had provided care and nurturing. They had taken care of adult members of the community when they became sick, cleaning their homes and providing food and rudimentary medicine. And, these new sisters had taught and fed the Ojibwe children for a full decade. But the Sisters of St. Joseph had not integrated into the community as well as their predecessors had done. They came to a society that had lost its sense of unity when it lost the traditional priest who spoke Ojibwe and the sisters who had become family members. And, they came to a society that was beginning to embrace a modernism that was reinforced by a true "native son." Like Fr. Sebastian Kneipp, Fr. Gordon had embraced the idea that religious and health care identities should be separate, an idea that would have been impossible for Midewiwin practitioners. According to the modern priest and his Ojibwe admirers, Midewiwin practices were cultural relics that had value in their maintenance; the sacred drum and the peace pipe were symbolic, as were the ceremonial dances and celebrations. On the other hand, real health care was backed by the government and science. It was "progressive."

Certainly, this new health care had its advantages; it profited from the knowledge of worldwide scientific discoveries and advances. The care that Cox had attempted to provide to the son of Shabogesic on an isolated reservation in 1888 was similar to the treatment that a similar injury would have received in the most modern contemporary hospitals; the wound had been cleaned, the bones had been reset, and the leg had been put

in traction. However, the new health care also had its disadvantages. It did not support the maintenance of traditions and a long-established culture. It was remote – the service Fr. Gordon promoted was directed by policy made and funded by Washington bureaucrats who did not understand real-world conditions at the LCO. And, when the Sisters of St. Joseph evacuated their mission, the LCO Ojibwe lost allies that could have tempered the modernity of the new scientific medicine with religious and holistic healthcare.

Fig. 3.1
The LCO medicine man, Neweiash.[119]

[119] "Neweiash wrapped in star quilt," Bureau of Catholic Indian Missions, 09-1 57-07, n.d. Courtesy of Department of Special Collections and University Archives, Marquette University Libraries.

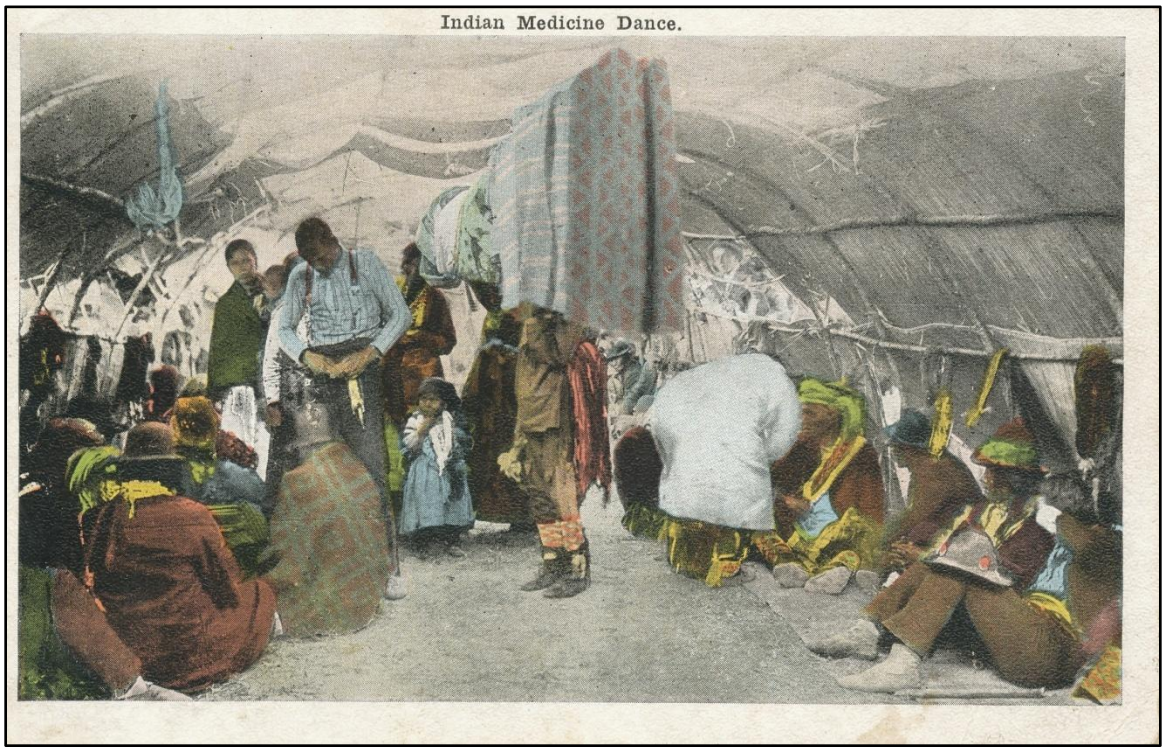

Fig. 3.2
"Wisconsin Indians. Interior view of Medicine Lodge, built of reeds and bark over a frame-work of poles. Indians inside are preparing for the Great Medicine Dance. Beaded moccasins, garters, belts, medicine bags and fine furs are worn as decorations in this dance, which lasts for several days. Young Indian holding medicine bag is to be initiated to the lodge; his squaw and papoose in rear. The furs hanging from the walls of the lodge near heads of sitting Indians are the finest otter skins obtainable. They are worn attached to a belt and dangle behind the dancer as he performs the dance. The value of the costume of a well dressed dancer is often $150.00 to $200.00."[120]

[120] "Indian Medicine Dance," (E.C. Kropp Co.: Milwaukee) n.d. Postmark is 12/17/1920. Postcard from author's collection.

Fig. 3.3
Europeans taking the Kneipp treatments, which included walking barefoot. Barefoot contact with snow or water was considered especially beneficial.[121]

[121] "Kneipp-Kur," (Photosport Neuchâtel) n.d. Postcard from author's collection.

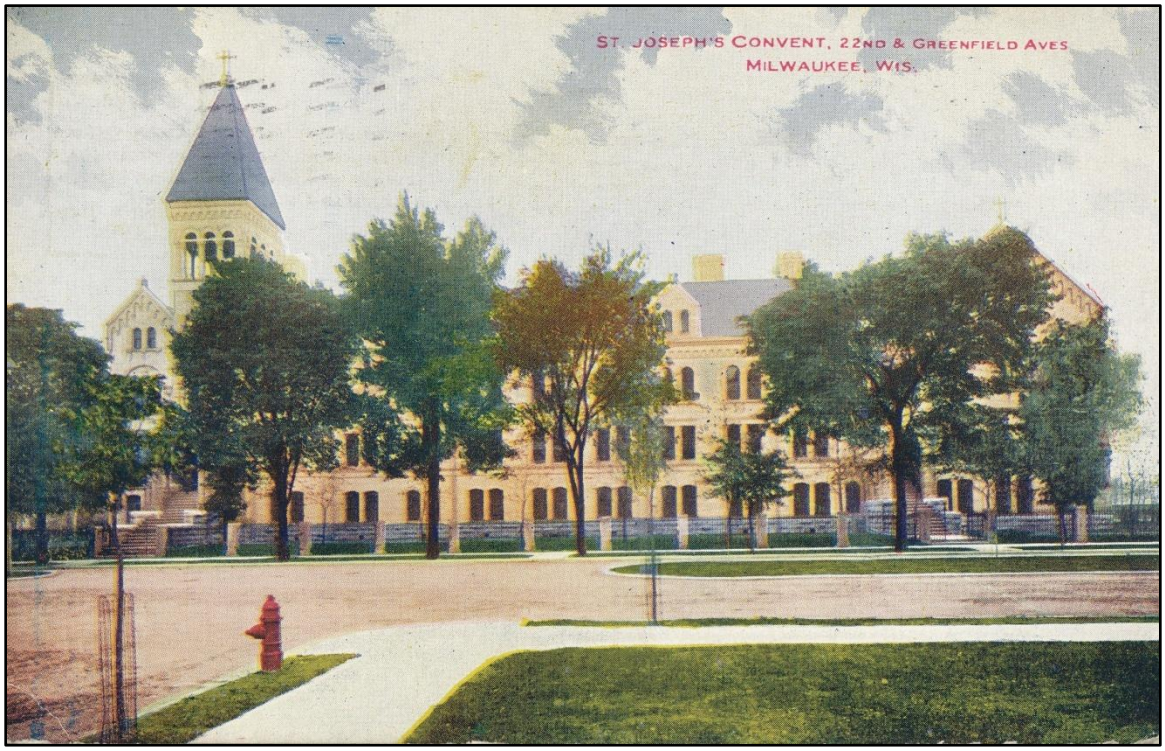

Fig. 3.4
The Milwaukee convent of the School Sisters of St. Francis. The street in the foreground is now Layton Ave.[122]

[122] "St. Joseph's Convent, 22nd & Greenfield Aves., Milwaukee, Wis.," (C.S. Henschel Mfg. Co.: Milwaukee) n.d. Postmark is 4/10/1910. Postcard from author's collection.

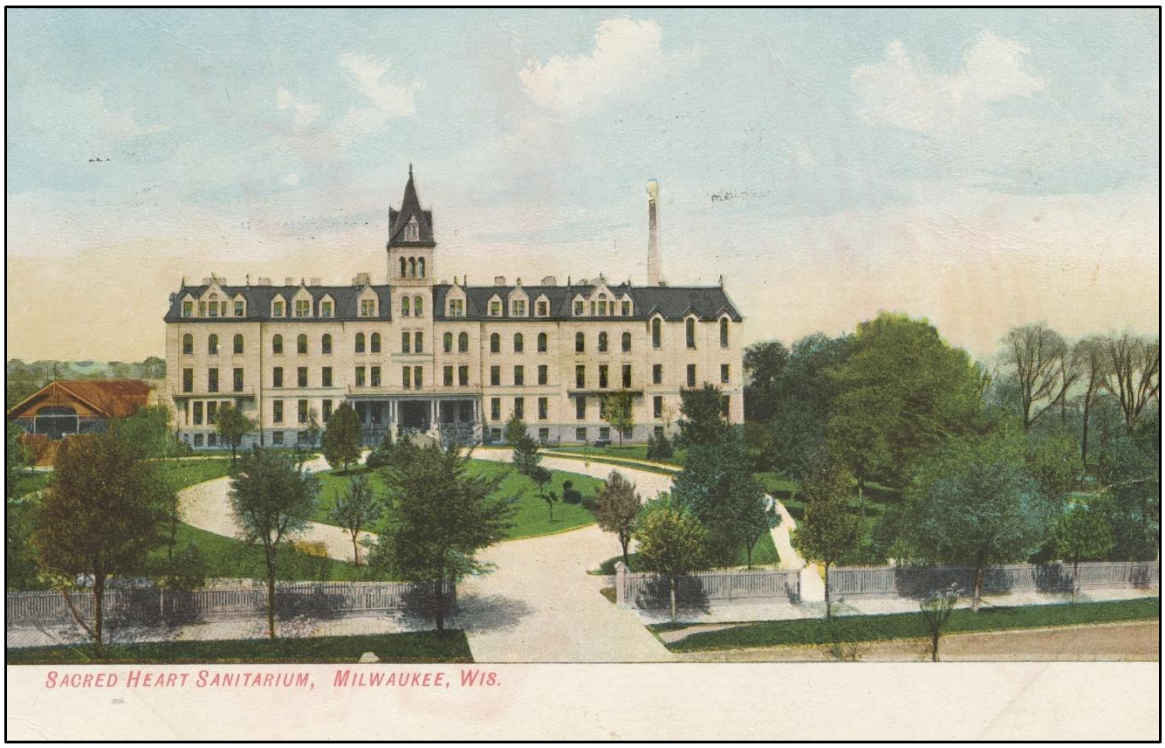

Fig. 3.5
The School Sisters' sanitarium, before expansion.[123]

[123] "Sacred Heart Sanitarium, Milwaukee, Wis." n.d. Postmark is 9/12/1908. Postcard from author's collection.

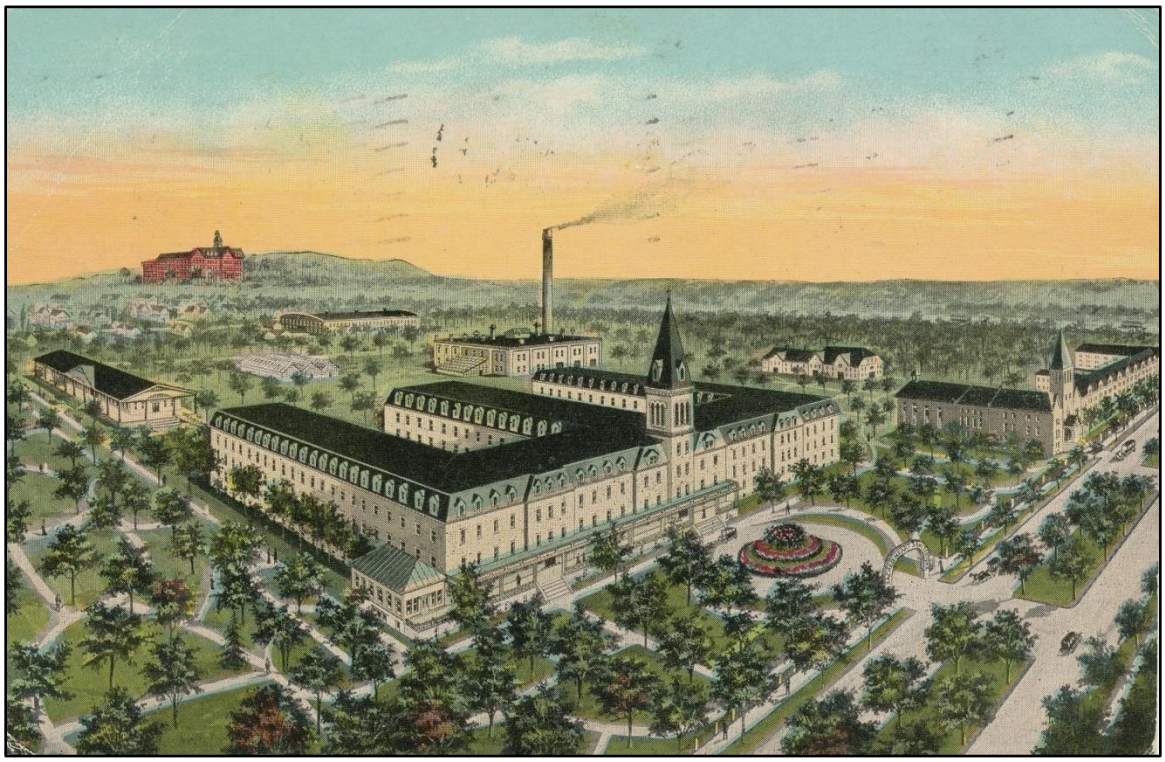

Fig. 3.6
The sanitarium and convent after expansion; the convent is the building on the far right.[124]

[124] "Sacred Heart Sanitarium (St. Mary's Hill in the distance), 575 Layton Boulevard, Milwaukee," n.d. Postmark is 5/13/1913. Postcard from author's collection.

Fig. 3.7
At his first mass, Father Philip B. Gordon is under the awning on the right of the front row. He is seated next to Rev. Joseph N. Koudelka, Bishop of Superior. Also under the awning in the front row are Father Odoric Derenthal and Father Chrysostom Verwyst.[125]

[125] "Jan. 6, 1914 – First Mass of Rev. Philip B. Gordan [sic], Odanah." Bureau of Catholic Indian Missions, 09-1 OS-02-08. Courtesy of Department of Special Collections and University Archives, Marquette University Libraries.

Fig. 3.8
Father Gordon and his good friend Dr. Montezuma[126]

[126] "Father Gordon and Dr. Montezuma, 1919," Bureau of Catholic Indian Missions, 09-1 57-04. Courtesy of Department of Special Collections and University Archives, Marquette University Libraries.

CHAPTER FOUR:
OPEN PORES, WIGGLERS, AND DEMONS:
AN ECUMENICAL GOSPEL OF GERMS

On June 30, 1937, Waishke Martin, "one of the oldest residents" of the Bad River Ojibwe reservation and a "high-degree member of the secret order of the Medicine Lodge" made an announcement at a Midewiwin ceremonial dance. Waishke stated that two tribe members had recently heard "voices of unseen persons," voices that were "warnings from the Great Spirit." This was a concern, "for similar voices had been heard in earlier days, about 1883, when a deadly epidemic of black measles" had raced through the community.[1] The following day, at the Totem Pole ceremony, the "master of the secret order" discussed the warning, and he cautioned participants that "this punishment had come upon the Chippewa people because they had neglected their duty to Gitche Manitou, the Great Spirit." After the ceremony, the Midewiwin master asked his assistants to "prepare some powerful medicine, which the people must keep in readiness in the event something should happen again."[2]

The Ojibwe who lived on the northern Wisconsin reservations in the 1880s believed that their recent "deadly epidemic of black measles" was the result of the people's neglect of Gitche Manitou.[3] At the same time, their European-American

[1] The term "black measles" likely referred to either severe measles or Rocky Mountain spotted fever. *Stedman's*, s.v. "measles: black."

[2] James Scott, "Totem Pole Ceremony," in *WPA Indian Research Project Collection, 1936-1940*, ed. Macaria Murphy (Milwaukee: Marquette University Department of Special Collections and University Archives, 1983), 23-4.

[3] Anthropologists who studied the Ojibwe at the time generally agreed "Although these herbalists are aware that certain plants or roots will produce a specified effect upon the human system, they attribute the benefit to the fact that such remedies are distasteful and injurious to the demons who are present in the system and

neighbors subscribed to a wide variety of beliefs regarding the cause of that illness and disease in general. Hayward's schoolchildren, for example, learned in their health and physiology classes that the diseases troubling them and their neighbors were not "caused by evil spirits," nor did they appear "arbitrarily." Instead, sickness was a "state" of bodily disharmony, a condition in which the body's mechanical functions were not working properly because they had been subjected to "abuse or misuse"; the malfunction led to the accumulation of bodily poisons.[4] Abuse that might lead to this condition included "the practice of eating snow," which, according to the city's newspaper, led "to much of the throat difficulty of children in winter or early spring."[5] An earlier edition of that newspaper had articulated other beliefs about the source of disease when it warned local parents that they ought to "exercise a little more care" and not let their children "come in contact" with anyone suffering from diphtheria. The paper further advised that parents should ensure that their "children are clean" as then "half the liability to sickness [would be] guarded against."[6]

Local doctor, John Trowbridge agreed with these last cautions that sickness was transmitted by contact both with dirt and with people who were already sick. In his 1886 report to the SBOH, Trowbridge stated that as the "streets and alleys" of Hayward had been "thoroughly cleaned," no residents would encounter any hazards to their health from

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to whom the disease is attributed. Many of these herbalists are found among women, also; and these, too, are generally members of the Midē'wiwin." Hoffman, *The Mide'wiwin*, 11.

[4] Joel Dorman Steele, *Fourteen Weeks in Human Physiology*, Revised and enlarged with selecting readings ed. (New York: American Book Company, 1888), 251-2.

[5] *NWN*, 30 April 1886.

[6] *NWN*, 5 July 1884.

that source. Danger could only come "through the soil in connection with the water supply."[7] After all, diseases appearing in another northern Wisconsin lumbering community, Hurley, seemed to originate in the soil. Hayward's newspaper had reprinted a notice in Hurley's *Workman's Gazette* which suggested that a "great deal of sickness" there was due to the high iron content in the water. The *Gazette's* editor affirmed another widely held belief about sickness when he added that the water was especially dangerous when "taken in conjunction with the oppressively hot weather."[8]

In the 1880s, there existed within a relatively small geographic area a wide variety of beliefs regarding the cause of disease. Disease was the result of supernatural forces or the consequence of a breakdown of the body's mechanical functions and its inability to rid itself of waste products. It was the end result of the application of unnatural stress, including extreme heat or cold. It was the product of contact with dirt, whether direct or indirect through the consumption of contaminated water. It was a reaction to atmospheric extremes. And, disease was carried in the body and transmitted directly from one person to another. By 1920, people living in northern Wisconsin no longer generally accepted this wide assortment of assumed causes of disease. Midewiwin practitioners continued to maintain that disease had a supernatural cause, that it was a result of the people's neglect of Gitche Manitou. Euro-American doctors, educators, and the general public, however, had begun to subscribe, with an almost religious dedication, to a modern model of sickness. Historian Nancy Tomes has called this modern paradigm the "'gospel of germs' and explains it as the belief that microbes cause disease and can be avoided by

[7] 10th *SBOHR*, 230.

[8] *NWN*, 14 August 1886. Hurley is about 85 miles from Hayward.

certain protective behaviors."[9] The transition from traditional to modern beliefs was a gradual and protracted process. Older residents continued to hold on to traditional assumptions regarding the causes of disease, despite efforts by government officials, educators, physicians, and community leaders to convince them to trust in the "gospel of germs." The gospel had to be cloaked in modernity, taught in schoolrooms, and evangelized from the pulpit. This new set of beliefs about the cause of disease, in short, had to be marketed to a public that was less than willing to buy.

The range of ideas in the area during the 1880s about the source of disease had its roots in long-established tradition. The first Euro-American physicians had practiced under a set of assumptions that had directed physicians in ancient Greece. These assumptions, articulated by Galen in the second century AD, asserted that the body operated on a balance of four basic humors: blood, phlegm, black bile, and yellow bile. When the four humors became imbalanced, sickness was the result. Treatment, then, was designed to restore balance by diminishing the damaged humor through bleeding, blistering, purging, vomiting, and sweating.[10] With the Enlightenment came a reassessment of the causes of disease. Paracelsus (1493-1541) argued that diseases had specific causes, which contemporaries explained as generally as the iatrophysical and the iatrochemical.[11] Supporters of the iatrophysical school "envisioned the body as a machine motivated by a 'life force' circulating through the nerves," while supporters of

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[9] Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1998), 2.

[10] John Duffy, *From Humors to Medical Science*, 7.

[11] Eric H. Christianson, "Medicine in New England," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1997), 52.

the iatrochemical "assumed that chemistry was the basis of physiology" and blamed sickness on "abnormal chemical reactions."[12] The Enlightenment ideas, in effect, only altered humoral theory; sickness could be the result of a damaged nervous "life force" or an "abnormal chemical reaction." However, treatment was still designed to restore the balance inherent in healthy bodies. The critical question centered on the cause of the imbalance. Humoral imbalance was caused by an individual's actions and behaviors; iatrophysical and iatrochemical imbalances were due to a host of physical and chemical causes, but most of these were external.

In investigating historical theories of causation in 1947, historian Phyllis Allen Richmond grouped the most widely accepted late 18th and early 19th century theories into broad categories, including "those based on marsh miasma, atmospheric causes, [and] chemical causes." The theory that had the most adherents was that of the miasma: fevers were caused by poisons in the air that could be attributed to "decaying vegetable matter, to stagnant water, to decaying bodies on battlefields, or to plain putrefying animal matter." A second belief was that fevers were caused by changes in the atmosphere. These changes could be as varied as the arrival of a comet, an increase in air pressure, or the passing of a thunderstorm or a fog.[13] A third general cause also depended on the condition of the air; doctors who believed in a chemical cause for fevers argued that the

[12] Duffy, *From Humors to Medical Science*, 13-14.

[13] Phyllis Allen, "Etiological Theory in America Prior to the Civil War," *Journal of the History of Medicine and Allied Sciences* 2 (1947), 492-4. Noah Webster, for example, noted that there was a "possible correlation between epidemics and comets, earthquakes, meteors, storms, … fog, and the aurora borealis."

chemical structure of the air itself was flawed in some fashion, thus creating a situation supporting a fever.[14]

All of these causes – miasmatic, atmospheric, and chemical – were variants on the humoral and iatrophysical/iatrochemical schools. In short, disease was a "systemic imbalance," and the "primary characteristic of sickness was the body's excessive excitement or enfeeblement." Treatments were based on the belief that the body had a "natural balance" that needed restoration, and the idea that there was a natural balance had humoral theory foundations. By the middle of the 19th century, physicians increasingly identified various "systemic imbalances" as specific diseases, but they continued to believe that "environmental influences," such as chemical changes in the atmosphere, could alter specific diseases and "nudge one disease into another." Sources of diseases were as "fluid" as the "disease entities" themselves.[15]

It was a different theoretical cause that ended up being the most long-lasting. According to this final theory, "disease was caused by minute animal or vegetable creatures … which were generally called animalculae." The conjecture was an old one; Richmond dated it back to the early Roman Empire. However, until the 1880s and after publication of a "translation of M. Magnin's *Bacteria*," American physicians were not generally receptive to the idea that there were tiny creatures or miniscule poisons that

[14] *Ibid*., 497. Some proponents of this theory argued that bad air had "lessened elasiticity" or that it contained "ozone, or oxidized nitrogen gas, or carbonic acid gas, … or suphurous emanations in general."

[15] John Harley Warner, "From Specificity to Universalism in Medical Therapeutics: Transformation in the 19th-Cetury United States," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1997), 87-89.

could cause disease.[16] Continuing her work on the development of germ theory in 1954, Richmond argued that germ theory, the supposition that many diseases are caused by microorganisms, was finally accepted as the most correct theory "almost immediately after Koch's demonstration of the tuberculosis bacillus and the statement of his postulates in 1882."[17]

More recent work on the development of germ theory refines this general timeline. Duffy asserts that by the end of the Civil War, most "well-educated American physicians" had allowed that cholera was spread through consumption of fecal matter, but a survey of common doctors "indicates that about half of them still believed that atmospheric causes were the prime factor in the spread" of that disease. [18] According to Tomes, Koch's breakthrough, in addition to discoveries made by Louis Pasteur, prompted the rapid acceptance by American physicians of the "general principle that microorganisms played a central role in causing communicable diseases."[19] And, with

[16] Allen, "Etiological Theory in America," 498, 518.

[17] Phyllis Allen Richmond, "American Attitudes toward the Germ Theory of Disease (1860-1880)," *Journal of the History of Medicine and Allied Sciences* 9 (1954), 451. For general historiography of the development of and the American acceptance of germ theory, see: Erwin H. Ackerknecht, "Anticontagionism between 1821 and 1867," *Bulletin of the History of Medicine* 22 (1948); ———, "Recurrent Themes in Medical Thought," *Scientific Monthly* 69 (1949); William Bulloch, *The History of Bacteriology* (London: Oxford University Press, 1938); and Phyllis Allen Richmond, "Some Variant Theories in Opposition to the Germ Theory of Disease," *Journal of the History of Medicine and Allied Sciences* 9 (1954). More recent histories that update this general historiography include: K. Codell Carter, *The Rise of Causal Concepts of Disease: Case Histories* (Burlington, VT: Ashgate Publishing Co., 2003); Anna Greenwood, "Lawson Tait and Opposition to Germ Theory: Defining Science in Surgical Practice," *Journal of the History of Medicine and Allied Sciences* 53 (1998); Nancy Tomes, *Gospel of Germs;* and Tomes, "The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and the Germ Theory, 1870-1900," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt & Ronald L. Numbers (Madison: University of Wisconsin Press, 1997).

[18] Duffy, *From Humors to Medical Science*, 169.

[19] Tomes, *Gospel of Germs*, 6.

each discovery of a new microorganism, the belief that all diseases had a bacterial source was strengthened.

Hayward's licensed and educated doctors quickly latched on to the germ theory and integrated ideas advanced by the scientific community into their regular practice. By 1905, Dr. Cox had assimilated germ theory into his practice so thoroughly that when he presented his paper, "Aseptic Obstetrics" to the 59th Annual Meeting of the State Medical Society of Wisconsin in LaCrosse, he had to remind Society members of the old days, when "frequently that much to be dreaded 'child-bed fever' occurred." Two years later, Cox continued his theme with a paper he read to the Washburn-Sawyer-Burnett County Medical Society, "Antiseptic Treatment of Typhoid Fever." And, in 1907, Cox briefly considered even leaving active practice in order to publish a journal that he would title *Antisepsis*.[20]

Dr. Trowbridge, the physician who was, compared to Cox, restrained in his acceptance of new-fangled machinery and ideas, also had clearly assumed germ theory as fact, although his experiences and connections with more traditional beliefs tempered that assumption. In his 1900 report to the SBOH, Trowbridge pointed out that while Hayward's water supply "looks bad in the summer," it was still "healthy."[21] This understanding of animalculae as relatively inoffensive was up-to-date, in contemporary medical understanding. Germs could not be seen by the naked eye, so their existence could only be proven, outside of the microscope, by the corresponding existence of

[20]Joseph P. Cox, M.D., "Aseptic Obstetrics," *WMJ* 4, no. 4 (1905), 121. Antisepsis is the "[p]revention of infection by inhibiting the growth of infectious agents," while asepsis is a "condition in which living pathogenic organisms are absent; a state of sterility." *Stedman's*, s.v. "antisepsis" and "asepsis."

[21] 18th *SBOHR.*

diseases. Trowbridge pointed out that Hayward had, among other diseases, "2 cases of typhoid fever, … 100 cases of diarrhoea with 4 deaths, [and] 10 cases of cholera morbus with no deaths," but "no known cases of disease" had been caused by the water supply.[22] Where the typhoid, diarrhea, and cholera germs were coming from was unknown, according to Trowbridge, but it certainly was not the dirty water that Haywardites bathed in, cooked with, and drank.

While Hayward's doctors were beginning to adopt germ theory as the major explanation for disease, the community had a much more complex understanding of the sources of illness. This understanding was based on the interaction of their understanding of the newer germ theory with a variety of older and more traditional theories, including those that Richmond had described as "those based on marsh miasma, atmospheric causes, … and animalculae."[23] For example, Haywardites subscribed to the miasma model, judging that foul smelling air initiated illness. They also believed that many of the "common diseases that we now know to be communicable" were "constitutional in origin, that is, the result of poor heredity complicated by unhealthy habits."[24] In addition to those theories, Hayward's citizens subscribed to a particularly Gilded Age faith in the importance of vitality, a faith that had humoral roots; Haywardites believed that the debilitation of an individual's natural vitality caused that individual body to

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[22] 18th *SBOHR*. Diarrhea is most likely transmitted through contaminated food or water; typhoid is transmitted "by food and water contaminated by feces and urine"; and cholera is transmitted "through ingestion of food or water contaminated directly or indirectly with feces or vomitus." Abram S. Benenson, ed., *Control of Communicable Diseases Manual*, 16th ed. (Washington, DC: American Public Health Association, 1995), 503, 96.

[23] Allen, "Etiological Theory in America," 492.

[24] Tomes, *Gospel of Germs*, 3-4.

malfunction.[25] And, some Haywardites, especially those with particularly strong connections to the LCO through ties of blood, marriage, or friendship, continued to believe that otherwise unexplainable diseases were the result of a vague offense committed against a deity. The interaction of these various ideas resulted in an illness model that was much more complex than the germ theory vs. miasma duality often depicted by historians studying the late 19th and early 20th centuries.[26]

Throughout the final years of the 19th century, Haywardites made it clear that they still subscribed to the old idea that illnesses were essentially miasmatic, that is, they were communicated through bad air, which could be identified by its smell. Home health care practitioners reading *Advisor* would note that "malarial fevers, intermittent, remittent, and congestive" were cause by "*miasm*, a poisonous, gaseous exhalation from decaying vegetation."[27] And, once a patient became ill, it was vital to supply the patient with pure air, which "should not be contaminated by passing over foul drains, privies, or other sources of infection, since … it depresses the physical forces and generates disease."[28]

Because the community was convinced of miasmatic dangers, it made concerted efforts to diminish opportunities for miasmas to develop, and it focused other efforts on

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[25] For more on the construction of Gilded Age masculinity and vitality, see: Gail Bederman, *Manliness & Civilization: A Cultural History of Gender and Race in the United States, 1880-1917*, (Chicago: The University of Chicago Press, 1995); Martin A. Berger, *Man Made: Thomas Eakins and the Construction of Gilded Age Manhood* (Berkeley: University of California Press, 2000); and Mark C. Carnes and Clyde Griffen, ed., *Meanings for Manhood: Constructions of Masculinity in Victorian America* (Chicago: The University of Chicago Press, 1990).

[26] For example, see: Valenčius, *Health of the Country*. "The introduction of germ theory and its microscopic world sharply fractured (though it did not destroy) a much more organic and holistic understanding of health and disease. Early-nineteenth-century people encapsulated in their notion of climate a whole worldview that was soon to come under sustained attack."

[27] *PMA*, 405; see Chapter 2.

[28] *PMA*, 378.

communicating strategies intended to lessen existing miasmas. Advising its readers on care in the sickroom, the *Republican* stated in 1896 that "one of the best disinfectants in the sick room is a basin of fresh water," as "water is a great absorbent of noxious gases." The editor argued that it was "not a theory, but an experience" that the water would gather "impurities" from the air and lead to a "nervous" patient's relief and "refreshing sleep."[29] The editor was echoing advice that local children were learning in their physiology classes at the local schools. Their textbook, Joel Dorman Steele's *Fourteen Weeks in Human Physiology* taught that

> If a pitcher of water be left uncovered in an occupied apartment for only a few hours, it will become foul from the absorption of the respired and perspired gases in the room. The colder the water, the greater the capacity to contain these gases. Water kept in a room overnight is therefore unfit for drinking, and should not be used even to brush the teeth or to gargle in the throat.[30]

Nearly every summer, the *Republican* printed complaints about garbage that had accumulated in local alleys and that sometimes spilled out into Hayward's streets. In July 1895, the editor admonished residents to clean the "back alleys throughout the city" in order to support the "health of our citizens during the hot weather."[31] In September of the same year, after the hottest months had passed, the editor continued to claim that the alleys needed to be cleaned and "put in a sanitary condition," as he was "afraid that

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[29] *HR*, 13 February 1896.

[30] Steele, *Fourteen Weeks in Human Physiology*, 318. In 1888, they Hayward school system reported that it was using Steele's book to teach physiology. *Biennial Report of the State Superintendent of the State of Wisconsin for the Two Years Ending June 30, 1888*, ed. State Superintendent of Schools (Madison, WI: Democrat Printing Co., State Printers, 1888).

[31] *HR*, 11 July 1895.

considerable sickness" will result from the disorder.[32] A month later, he remarked that it was "strange, indeed that there is so little sickness in Hayward when one becomes familiar with the condition of the alleys in the rear of the business places on main street."[33] The following summer, again in July, the editor pointed out the existence of a "run of typhoid fever and diphtheria" in "many towns" in the northern part of the state. He claimed, dubiously, that "Hayward has always had the reputation of being one of the most healthy towns in the state," a condition that would not remain unless "health officers make a tour of the city, and an examination of the back streets and alleys and have the garbage and refuse matter removed."[34] Clearly, the town officers took notice, as only a week later, the *Republican* noted that the "rubbish" was being removed from the "alleys, where the odor is far from being pleasant."[35]

Frequent references to dangerous odors in conjunction with the alley rubbish clearly indicates that, at least before 1896, the editor believed in a miasmatic view of disease causation. Two years later, however, the *Republican* noted that on the approach of spring, people should clean up their yards. The editor advocated the raking and burning of leaves, which would improve the "appearance of the premises, besides removing a source of evil, as rubbish conceals disease germs."[36] The difference between the perceived causes of disease – miasmas and germs – in those two years did not change

[32] *HR*, 5 September 1895.

[33] *HR*, 10 October 1895.

[34] *HR*, 9 July 1896.

[35] *HR*, 16 July 1896.

[36] *HR*, 28 April 1898.

the advice that the editor was giving; he still was reminding Haywardites that they should remove the rubbish, as it would lead to sickness. The subtle change in the local discourse indicates, however, a growing acceptance of the idea that germs were the primary cause of disease.

While Haywardites remained convinced that illnesses could be caused by miasmas, they also held onto the traditional idea that changes in the atmosphere could cause sickness. When the weather became cold in 1894, the local paper warned that people were in danger of contracting typhoid and diphtheria.[37] This was not an unreasonable warning, as close quarters increased the likelihood of person-to-person transmission of these communicable diseases. The increased danger, however, was not attributed to close quarters. The following January, the *Republican* noted that "on account of the sudden changes of weather of late, quite a number are complaining of bad colds and sore throats."[38] In late September, 1898, the *Republican* observed that "since the sudden change in the weather there are many people in Hayward that are suffering from bad colds and hoarseness and some can hardly speak above a whisper. … The sudden and severe change of the weather is beginning to tell on the health of our people, as many are complaining of bad colds."[39] These were not isolated warnings; almost every winter in the 1890s, the paper ran a notice regarding the "unusually heavy" death rate. Apparently each November and December, like clockwork, "Death [was] busy … sparing neither youth, manhood, prime, nor old age." Therefore, the *Republican* warned,

[37] *HR*, 20 December 1894.

[38] *HR*, 31 January 1895.

[39] *HR*, 22 September 1898.

"everybody should take the best care of themselves, avoiding needless exposure, and fortifying themselves against the sudden atmospheric changes that daily take place." Not limiting their warning to the cold months, the *Republican* also printed nearly identical cautions in the spring.[40]

The summer also held atmospheric dangers. It was, in short, much too hot. No matter what dire warnings the *Republican* had printed about dangerously cold winters, the dog days of summer were called "the most unhealthful season of the year."[41] Haywardites were warned to be "careful of their diet" so as not to be "overcome by heat." The best advice was to eat light, shun "iced and especially alcoholic drinks," and to drink "cooled buttermilk or lemonade."[42]

A more candid explanation for the dangers of heat centered on a model that, in the wrong hands, could became a simple explanation for nearly every disease: illnesses were caused by exposed and unprotected pores. The pores were an open window, a pathway in which poisons could enter the body and a venue through which essential vitality could escape. In August 1895, the *Republican* warned that "there is really more danger from pneumonia in the very hot spells of summer, because people sit in drafts to keep cool. The pores are open from the profuse perspiration, and the draft goes right through them to the vital parts."[43] Steele agreed with this warning, in general principle. His readers learned that women should not wear makeup because "paint and powder … fill the pores

[40] *HR*, 31 November 1893. See also 14 December 1893; 7 June 1894; 16 May 1895; and 11 November 1897.

[41] *HR*, 27 July 1893.

[42] *HR*, 22 July 1897.

[43] *HR*, 1 August 1895.

of the skin [and] often contain substances which are poisonous, and being carried in … cause disease."[44] Although it was important, in some cases, to keep the pores protected, the problem with pores was that they also appeared to function to expel the body's own poisons and thus keep it in balance. This was the heart of the pore mystery: what was the best manner of keeping the pores protected from unseen poisons and drafts yet keep them open so they could expel inner poisons, and how "open" should the pores be? Steele asserted that "sudden changes in temperature" would produce diseases like colds and rheumatism because the pores would be too open or closed, so one should wear flannel "next [to] the skin, in all seasons of the year." However, one should also avoid perspiring "abundantly," as that may "weaken the body."[45]

The problem with pores that opened too wide or kept closing too tightly was that if the body was already weakened, if one's vitality was already drained, an open pore might provide an opportunity for disease to take hold. It was, therefore, important for individuals to keep themselves out of drafts and to keep their perspiration at acceptable levels, but it was more critical for individuals to maintain vitality.

Energy spent on learning could sap a person's vitality, especially the vitality of the most vulnerable. Consequently, Hayward's women were cautioned against expending too much of their physical energy in activity and mental energy in complex reading or studying. How these admonitions were applied, however, indicates that the most vulnerable among Hayward's women were the wives and daughters of the

[44] Steele, *Fourteen Weeks in Human Physiology*, 153. This piece of seemingly strange advice actually had some validity. Arsenic was once considered to be good for pale complexions, belladonna was used to create beautiful eyes, and the Botox that we use today to get rid of wrinkles is a form of botulism.

[45] *Ibid*., 156, 160.

community's leaders. Mrs. R.L. McCormick and Mrs. W.H. Guy were very carefully protected, and their activities carefully prescribed; the wives of the NWLC laborers expended plenty of physical energy in creating and maintaining homes. And, considering the amount of work that was expected of them, the sisters who worked at the LCO mission and at the Hayward Indian School certainly must have been considered as invulnerable as the priests who "supervised" their rigorous activities.

Schoolchildren, particularly those who were very young, were especially at risk. In 1893, the *Republican* editorialized that "a physician should be employed whose duty it should be to make periodical visits to the school and see that no child is worked or taught beyond its mental or physical strength. The mental and physical strength and well being of the young should receive more attention."[46] Even members of the medical profession who theoretically subscribed to germ theory supported the importance of the vitality. In 1895, the *Republican* reported:

> A physician of a neighboring board of health has concluded that two hours in the forenoon and one hour in the afternoon is as long a time as children can be profitably employed in school. He advocates eighteen hours a week as the limit for school children under twelve, and says that it would be better, from a purely hygenic point, to make Wednesday the weekly holiday rather than Saturday, and to have examinations to occur at the beginning of a school term rather than at the end.[47]

While the schools represented a danger to the vitality of the youngest of students, they also presented an opportunity to teach about other dangers to the vitality. Older students, for example, were to be taught that "society votes" the cigarette "a nuisance. … The doctors assert that it poisons vitality and produces epilepsy. School boards instruct

[46] *HR*, 21 September 1893.

[47] *HR*, 31 January 1895.

their teachers to make a vigorous crusade against it."[48] Steele went further, arguing that chewing tobacco was far more harmful than cigarettes. The method of ingestion insured that "a greater proportion of the poisonous alkaloids … is carried into the system" and ultimately resulted in "impaired nutrition, a poisoned circulation, [and] a stupefied mind and conscience."[49] And even more harmful than chewing tobacco was liquor, which "impaired" the nervous system, "weakened" the digestion, and "impoverished" the blood.[50] The consequence of these filthy habits, the students learned, was a diminished vitality and a deteriorating ability to resist disease.

A weakened vitality, whether poisoned by tobacco or sapped by education, could lead to terminal insanity. Mrs. John Moore, for example, was a healthy, 28 year old woman who suffered from this type of quick decline. In the beginning of August 1899, "her queer actions attracted the attention of her husband and relatives," who called on Drs Trowbridge and Cox for assistance. The doctors adjudged her to be insane and had her committed to the state mental hospital in Madison, where she died only a few days later. Mrs. Moore's friends, neighbors, and relatives had varying opinions regarding her insanity; "some claim[ed] it was brought on by over work, while others are of the opinion that too close attention to reading and studying is the most reasonable cause."[51] Whether her vitality was sapped by overwork or by too much reading, Haywardites understood that her loss of vigor led to her insanity and death.

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[48] *HR*, 14 January 1897.

[49] Steele, *Fourteen Weeks in Human Physiology*, 179.

[50] *Ibid*., 181.

[51] *HR*, 3, 10 August 1899.

Sometimes there just was no clear explanation for the loss of vitality an individual seemed to experience. In those cases, Haywardites could point to predisposition; the body must have been inherently weak.[52] If an illness was constitutional, it was the result of a body's inborn inability to deal with the stresses of heat or cold, the effects of bad air, or the pores that had opened and released too much energy. Rheumatism was an undefined "disease of the blood."[53] Typhoid fever was caused by a germ, but that germ had to act "upon a susceptible system."[54] The *Advisor* counseled its readers that sometimes there was just no clear explanation for a constitutional illness. It maintained that:

> Scrofula may be attributed to various causes. Observation has shown that ill-assorted marriages are a prolific source of scrofula. Both parents may be not only healthy, and free from hereditary taints, but robust, well-formed physically, perfectly developed, and yet not one of their children be free from this dire disease.[55]

Hedging its bets, the *Advisor* went on to advise that scrofula could be caused by "depletion of the blood" through almost any means, including a lack of food, vegetarianism, bad medicines, "excessive mental or physical labor," and "too early use and abuse of the sexual organs."

The *Advisor's* explanation of the relationship between disease and an inherent tendency to weakness was particularly clear in the case of consumption. According to

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[52] For more on the manipulation of ideas of heredity, see Chapter 6.

[53] *PMA*, 426.

[54] *PMA*, 407.

[55] *PMA*, 447. Both scrofula and consumption are caused by the same bacteria; consumption is pulmonary tuberculosis, while scrofula is a tubercular infection in the neck. *Stedman's*, s.v. "consumption" and "scrofula."

the *Advisor*, consumption had only two sources: a *predisposition* to the disease and a *proximate* cause. Predisposition depended on "*anything* which impairs the vital forces and interferes with the perfect elaboration of nutritive material." Included in the list of *anything* was heredity, "debility of the parents," changes in the climate, "sedentary habits," and depression. Proximate causes were the triggers that pushed predisposition into active infection. Among these were:

> dyspepsia, nasal catarrh, colds, suppressed menstruation, bronchitis, retrocession of cutaneous affections, measles, scarlatina, malaria, whooping-cough, small-pox, continued fevers, pleurisy, pneumonia, long-continued influence of cold, sudden prolonged exposure to cold, sudden suspension of long-continued discharges, masturbation, excessive venery, wastes from excessive mental activity, insufficient diet, both as regards quantity and quality, exposure to impure air, atmospheric vicissitudes, dark dwellings, dampness, prolonged lactation, depressing mental emotions, insufficient clothing, improper treatment of other diseases, exhaustive discharges, tight lacing, fast life in fashionable society, and impurity and impoverishment of blood from any cause.[56]

Despite the long list of proximate causes and the predisposing causes that included *"anything,"* the *Advisor* admitted that "of just what tubercular matter consists, is still a subject of controversy."[57]

As Haywardites confronted the existence of disease, then, they had a long list of causes upon which they could lay blame. The alleys that remained unclean and smelled bad could have produced a produced a dangerous miasma. Changes in the weather, especially when they were rapid, could have opened or closed the pores too quickly; the atmospheric variations could also have caused drafts that sapped vitality. Perhaps, the ill

[56] Dyspepsia is indigestion, scarlatina is mild scarlet fever, pleurisy is a lung infection, and venery is sexual conquest. *Stedman's*, s.v. "dyspepsia," "scarlatina," "pleurisy," and "venery."

[57] *PMA*, 499.

individual had sapped his or her own vitality through ignorance or carelessness, and the vitality, to begin with, may have been inherently weak. Overall, the explanations for disease boiled down to an imbalance in the humors or iatrophysical and iatrochemical origins. A body that was in balance would not lose its vitality, nor would its pores open too wide or remain closed. Weaknesses that were physically or mentally induced were iatrophysical in nature, and miasmatic air would certainly cause an iatrochemical imbalance. As Steele taught his students, when:

> all the organs work in harmony, we are well; when any derangement of these functions occurs, we are sick. Sickness is discord, as health is concord. If we abuse or misuse any instrument, we impair its ability to produce a perfect harmony. A suffering body is simply the penalty of violated law.[58]

And of course, when disease struck unexpectedly and inexplicably, Haywardites could resort to the most traditional of all the explanations for illness: it was "God's will" or the consequence of inattention to Gitche Manitou.

After Koch's discovery of the tuberculosis bacillus, the traditional explanation of the disruption of humors was less satisfying. The idea that germs were a general cause of disease began to be feasible and more acceptable, especially when the answer to an unexplained disease or death was uncertain. After all, locals had held onto the old theory that diseases could be caused by tiny animalculae, especially those that existed in the water. No matter what Dr. Trowbridge reported to the SBOH in 1900, Haywardites and the people living in surrounding, smaller communities believed that dirty water was a danger. In 1893, the *Shell Lake Watchman* had advised locals to look at their water in the sunlight and judge for themselves what quality water they were drinking. The editor of

[58] Steele, *Fourteen Weeks in Human Physiology*, 251-2.

that paper reported that he "heard a man say that he believed nine-tenths of the sickness here was caused by the water," which, the paper reported, was full of "wigglers." The *Watchman* reasoned that "such foul water put into the stomach, and circulating through the human body must cause a great deal of ill-health."[59]

A decade later, the locals continued to complain about the water supply, and they expanded upon the description of animalculae and particulate matter as "wigglers." In early May 1904, Haywardites circulated a petition asking the town board to clean up the town's water supply. Clearly, the petitioners recognized that the water was a source of illness. Their reasons, spelled out in the *Republican*, show that Haywardites subscribed to a variety of theories regarding the causes of disease existing in that water. The petitioners noted the "accumulation of slime on the bottom [of the pond] which is well calculated to breed almost anything." The pond was also filled with the bark from the "forty million feet of logs" that were dumped into the pond and that were going to the mill; the petitioners noted that "the soaking out process … takes out the oil and pitch [from the bark] and leaves it in the water." And, to add to the problem, the sewage from the Hayward Indian School "flows into the pond only a short distance from the intake and it cannot be said that the impurities have been taken out of it in the short distance the water travels." The petitioners asked that a well be drilled in a "suitable place where water can be found in great abundance and perfectly clear and free from iron." The petitioners concluded that "we must not have an epidemic of typhoid fever here."[60] This instinctive understanding that the slimy NWLC pond water was a danger to the

[59] *Shell Lake Watchman* reported in *HR*, 7 December 1893. Shell Lake is only thirty miles from Hayward.

[60] "Pure Water Needed," *HR*, 5 May 1904.

community was later proven to be valid; almost twenty years later, Hayward still struggled with its water supply. The situation finally captured the attention of the SBOH in 1920, when testing proved that the water was so dangerous that citizens were warned to boil it before consumption.[61]

Repeatedly, the *Advisor* had linked specific diseases, like typhoid fever, with the traditional matrix of causes. Herpes, for example, was "not contagious." Instead, it was caused by temperature variation, "violent emotions, excessive exertion, irritation of the skin," and a systemic lack of normal muscle tone.[62] Rickets was connected to "cold, damp, … ill-lighted and imperfectly-ventilated" places and among people with unhygienic "habits."[63] Malarial fevers had their foundations in "*miasm*¸ a poisonous, gaseous exhalation from decaying vegetation, which is generally most abundant in swamps and marshes, and which is absorbed into the system through the lungs."[64] In fact, while dry air was "remarkably beneficial," any air that was moist and "charged with … decay [was] exceedingly baneful, introducing diseases under various forms."[65] And diarrhea, cholera infantum, and dysentery were produced by "exposure to cold and wet, or by improper and indigestible articles of food, such as unripe fruits, salads, pastries," and other food that disrupted "normal operations of the digestive apparatus." These

[61] *SCR*, 22 January 1920.

[62] *PMA*, 439.

[63] *PMA*, 453-4. Rickets describes soft bones that are a consequence of a lack of sunlight and vitamin D. *Stedman's*, s.v. "rickets."

[64] *PMA*, 405. Malaria is caused by a mosquito-borne parasite. *Stedman's*, s.v. "malaria."

[65] *PMA*, 228.

digestive diseases also could be triggered by "inhalation of impure air," and epidemics could begin "due to some peculiarity in the condition of the atmosphere."[66]

At the same time, however, the *Advisor* introduced to its readers the idea that germs produced disease. While epidemics could be miasmatic in origin, they also could be "due to germs which float in the atmosphere, enter the body, and produce disturbance by the development within the body of parasitic life."[67] Those germs could also be present in milk or water. Diphtheria, for example, which was also described as being due to the consumption of indigestible food and exposure to a damp climate, was ascribed to germs that could be "carried in milk or water, and the germs [could] attach themselves to furniture, walls, [and] clothing."[68]

In the late 1890s and into the early 1900s, the *Republican* had also begun to explain disease outbreaks using germ theory. In 1902 during an epidemic of scarlet fever, the editor of the *Republican* reported that a "female peddler of a rather Latin appearance" had been seen around town, entering homes without deferring to any quarantine. The editor clearly indicated that the problem with this peddler was her mobility. He pointed out that people "of the class" that would be "passing from house to house … are not always of the cleanest type." The woman was an ideal carrier of disease because her "vocation brings [her] into contact with almost everybody and everything." Ten years earlier, the editor might have dwelt, instead, on the rubbish in the alleys or on

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[66] *PMA*, 556.

[67] *PMA*, 230-1. "For it is exceedingly probable that the germs which lodge in the air-passages, or find their way with the saliva into the stomach with its absorbent system, are those which sow in the body epidemic disease."

[68] *PMA*, 414.

the heat of the summer sun. This problem with this peddler was that she was "passing from house to house." And, since people of that "class … are not always of the cleanest type" she would be apt to pick up the germs in one home and pass them to the next.[69]

It was this increasingly vocal acceptance, on the part of the media, the school system, and Hayward's physicians, that germs were the source of disease and the growing rejection of the idea that vague bodily imbalances resulted in disease that would prompt Haywardites to eventually agree to government- and physician-promoted limits on individual liberties. Haywardites continued, well into the 1910s, to argue that some diseases were the result of the loss of vitality and that others were caused by changes in the seasons, improper diet and clothing, or bodily poisons that were not appropriately excreted. And, they continued to believe in the absence of other evidence that inexplicable illnesses were the consequence of some supernatural offense. As the older generation gradually disappeared, and the generation who had learned germ theory in new versions of the physiology texts became Hayward's leading citizens, the belief that germs were *the* cause of disease became dominant. The idea that disease had a supernatural source was ascribed to superstition and old-fashioned peoples like the Midewiwin practitioners who continued to dance at traditional feasts and listen to voices who warned of epidemics.

[69] *HR*, 26 June 1902.

CHAPTER FIVE:
SCARLET FEVER AND WHITE PLAGUE:
VOLUNTARY SACRIFICE OF INDIVIDUAL LIBERTY

In mid-December, 1901, Sawyer county clerk Otto Christianson's little girls, 3 year-old Elen and 2 year-old Augusta, suddenly fell ill, scaring the Christiansons' maid so severely that she "went into hysterics and remained in an unconscious condition much of the time for three or four days." While Hayward's physicians had reported that the city was experiencing "but little sickness" only weeks before, it was increasingly clear that Hayward was on the brink of a major epidemic, one that would do more than scare the Christianson maid into fits of unconsciousness. The *Republican* had already begun to print notices about the epidemic, calling for the board of health to "use every precaution against the spread of scarlet fever," no matter how "severe" those precautions were "with those who are afflicted."[1] By Christmas, the pre-teen daughter of Mr. & Mrs. Lars Olson, Maggie, had died, three days after contracting "one of the most malignant cases" of scarlet fever the doctors "ever had to contend with."[2] And within a month, the three-year-old child of Mrs. Harry Lawrence died of the fever only minutes after the mother died of an undetermined blood infection, an illness that was likely directly related to the child's scarlet fever.[3] By that time, the Christianson maid had fled to her family home in

[1] *HR*, 16 December; 21 November; 16 December, 1901.

[2] *HR*, 25 December 1901. Pre-1907 death records state that she was 12, while the *HR* reported her as only 10. Pre-1907 death records, however, are incomplete; deaths that were reported in the newspapers do not always appear in the county clerk's record book. Reports of births are also sketchy, at best.

[3] *HE*, 22 January 1902. Hellen Lawrence, 20, had peritonitis for one week, according to the pre-1907 death records. The *HE* claims she died of pyaemia. Peritonitis is an "inflammation of the peritoneum," the lining of the "abdominal cavity." Pyaemia is also called septicemia, a "systemic disease caused by the spread of

Phipps even though it had become clear that the Christianson daughters only had suffered "severe colds" and not the fever.[4]

Like most American communities in the late 1800s, Hayward experienced frequent epidemics and endured high levels of endemic diseases. The city's pre-1907 death records are full of clusters of diphtheria, typhoid, and scarlet fever. The frequency of entries listed as tuberculosis, pneumonia, and tubercular meningitis in those same death records underscore Hayward's high endemic tuberculosis death rate, which for the 1905-1906 year was the fourth highest rate in Wisconsin.[5] And, the *Republican* noted in January 1902, at the beginnings of what would become a year-long fight against scarlet fever, that "scarlet fever, diphtheria and other contagious diseases … are raging to an alarming extent in many localities."[6] Diarrhea, with any of a number of causes, was a frequent cause of infant death, and the smallpox epidemics that frequently hit the lumber camps continually threatened to spread to the city.

Given the constraints of scientific medicine before the advent of penicillin and other antibiotic therapies, the doctors could not do much to prevent the high mortality rate that these diseases exacted from the population. What the doctors could do was use traditional remedies; they instituted quarantines and persuaded the locals to report

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microorganisms and their toxins via the circulating blood." *Stedman's*, s.v. "peritonitis" and "pyemia." The doctor, relying on clinical evidence, would have labeled the infection according to its location, thus the diagnosis of peritonitis. According to Benenson, group A streptococci causes both scarlet fever and septicemia.

[4] *HR*, 16 December 1901. Phipps was only about 5 miles away, but it had the advantage of being in a very rural area.

[5] 21st *SBOHR*, table 104.

[6] *HR*, 2 January 1902.

possible cases of any contagious diseases. When one of Eugene Buell's four children contracted scarlet fever in February, 1898, Dr. Trowbridge "at once ordered the house quarantined," as he hoped "to confine the disease to that one case, and prevent as much as possible the spreading of it."[7] In early June, 1900, during another scarlet fever epidemic, the local board of health found it necessary to remind Haywardites that they had to "immediately" report even suspected cases of scarlet fever "for the safety of the general public." Citizens with a "disregard" for this regulation would be "prosecuted and fined."[8] The local board of health also periodically ordered that the streets and alleys be cleaned, as the garbage that accumulated there was suspected of being the source of much illness.[9]

The problem with the local board of health ordering quarantines, work crews, and disease reporting was that each of these directives potentially infringed on the individual liberties that Haywardites enjoyed as Americans. A quarantine *may* have protected the larger community, but it certainly restricted the activities of the family members of an ill child, a situation that could be devastating for a family living on the edge of subsistence and dependent upon a father's ability to earn a daily wage. Reports of a contagious disease's progress through the community could help the doctors be proactive in their fight against diphtheria or typhoid fever, but the act of reporting required an acceptance of the authority of the medical man and of the board of health over the independence of the individual. Workers who were hired by the city to clean the alleys and streets earned money doing so, but the money they earned was taxed from the community at large.

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[7] *HR*, 17 February 1898.

[8] *HR*, 7, 14, 21 June 1900.

[9] See Chapter 4.

Hayward was, in effect, running into the same difficulty that other communities had experienced - a conflict between the ideal of American liberty and individual freedoms and the obligation the government had to protect the citizens it served. How much individual freedom could be curtailed in the name of protecting the public health, especially when that protection was dubious, at best? By the end of the 1910s Hayward's doctors had discovered, as had boards of health in communities throughout the United States, that coercion was ineffective, but efforts to curtail epidemics through voluntarism were efficient, especially those that relied on appeals to Americanism.

According to current research, scarlet fever is one of several maladies caused by group A streptococci. Among those illnesses are strep throat, impetigo, puerperal (childbed) fever, erysipelas, and toxic shock syndrome.[10] Hayward had its share of these illnesses; Judge Brophy and JL Holman both suffered from erysipelas, and many of Hayward's young mothers died soon after giving birth.[11] Group A streptococcus diseases are "common in temperate zones" and can be "endemic, epidemic or sporadic in character." Although the bacteria can strike throughout the year, "cases … peak in late winter and early spring."[12] Hayward's experiences with this bacteria reflect this model; diseases associated with group A strep were endemic, occasionally spiking and

[10] Erysipelas is a streptococcus infection that is characterized by swollen and hot skin "eruptions" accompanied by "severe constitutional symptoms," while impetigo is usually a staphylococcus or streptococcus infection on the face. *Stedman's*, s.v. "erysipelas" and "impetigo."

[11] *HR*, 22 February 1894; 16 September 1897. According to the pre-1907 death records, Mrs. John Welch, 46 died one week after confinement in October, 1897, and Horna Jorgenson, 28, died in May, 1899 of "purperal fever." Other postpartum deaths were reported in the local newspapers but were not reported as such in the pre-1907 records. One cannot be sure that these deaths were due to the group A streptococci.

[12] Benenson, ed., *Control of Communicable Diseases Manual*, 441.

periodically becoming epidemic in nature.[13] Scarlet fever patients experienced the fever and sore throat common among victims of strep throat. In addition, they presented with a sandpaper-like rash that caused desquamation, a peeling of the skin "in scales or shreds," during which they were still contagious.[14] Even in the age of antibiotic therapy, scarlet fever has a "case-fatality rate in some parts of the world … as high as 3%."[15]

By spring, 1902, it was clear to all of Hayward that the community's children were in danger of dying in a scarlet fever epidemic, and the statistics from four weeks in March and April confirmed this fear. In late March, 9 year old Florence died after her ten-day fight with the disease, and within weeks, the fever had taken an especially malignant turn.[16] Seven year-old Hans had it only five days before he died on April 5th. Siblings Lituro, 20, and Lillie, 9, both died on the 13th; Lituro had the fever for six days, while Lillie was only ill for two. Twelve year-old Ester died the next day, having been sick for eight days. Siblings Harry, 2, and Zoe Rogers, 4, died on the 16th and the 17th, both only having been ill for four days. On the 19th, Robie, the brother of Lituro and Lillie, died after having the fever for five days. And Harry Holt, 10, died on April 20th, after fighting the fever for only three days.[17]

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[13] According to Benenson, endemic diseases have a "constant presence … within a given geographic area," while epidemic diseases are "occurrence[s] in a community or region … with a frequency clearly in excess of normal expectancy." *Ibid*., 535.

[14] *Ibid*.; *Stedman's*, s.v. "desquamation."

[15] Benenson, ed., *Control of Communicable Diseases Manual*, 439.

[16] "Pre-1907 Wisconsin Deaths," WHS.

[17] *HE,* 16 April 1902; "Pre-1907 Wisconsin Deaths." Zoe Rogers is listed in the official records as Joe.

Three days after the Holt boy had died, on April 23, the *Enterprise* reminded its readers that "all Scarlet Fever patients should be regarded as sources of danger to others," a situation which demanded "the immediate and strict isolation of all who are attacked by this disease." This isolation, and the closing of the local schools, were "regulations" that the "local boards of health [had] full power to enforce."[18] By the end of April, those regulations had been put into place, as the editor of the *Enterprise* asked Hayward's citizens to examine their activities to ensure that they were complying with the "rules of the board of health." The *Enterprise* declared that "it is very evident that the citizens generally are observing these rules," but the editor questioned whether or not "the regulations [were] being followed in EACH and EVERY case." The fact that there continued to be "new cases reported within the last day or two" was evidence that "someone is not complying with the law."[19] The schools had closed for the rest of the school year, and families with sick children were being quarantined.[20]

However, it was clear that Haywardites did not entirely respect quarantine conditions. In late June, the "female peddler of a rather Latin appearance" who had been "making the rounds of the town" continued "going from house to house and entering home after home"; the fact that Haywardites continued to let her into their homes indicates their disregard for the official orders.[21] The Sawyer County Board of Health, which by state law was supposed to report on and respond to emergency situations like

[18] *HE*, 23 April 1902.

[19] *HE*, 30 April 1902.

[20] *HR*, 5 June 1902.

[21] *HR*, 26 June 1902.

this, could put a quarantine in place, but it could not force Hayward's citizens to comply with that quarantine. The *Republican* pleaded with its readers to "co-operate with the authorities in the efforts to maintain the health of other people," and to "consider the dangers to which they are exposing their neighbors, friends and even relatives, by their laxity."[22] In late August, a doctor from Chippewa Falls stated that Hayward's doctors were doing all that could be done regarding the epidemic. This was further proof, the *Republican* argued, that "it is 'up to the people' themselves to assist in the stamping out of the dread disease."[23]

No matter what the doctors did, no matter how closely Haywardites followed the quarantine rules, the epidemic continued to run its course. In May and June, two more children died. Then in July, six additional children succumbed to the fever, including two sets of siblings. In August, another eight children died, including one set of siblings. The Sanstrom baby, who was only one year-old, died within a day of coming down with the disease. One child died in October. On November 29th, 2 year-old Edwin died after a two day illness; his six year-old sister Sophia became ill two days later, and after another two days, she also died. Finally in mid-December, the three year old daughter of the Johnsons became the last official casualty in an epidemic that had lasted a full year.[24]

For his report to the SBOH that year, Dr. Trowbridge claimed that "the law requiring the report of dangerous contagious diseases is observed." However, he also admitted that "in spite of utmost precautions," scarlet fever "has continued to break out."

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[22] *HR*, 26 June 1902.

[23] *HR*, 27 August 1902.

[24] "Pre-1907 Wisconsin Deaths," WHS.

Pre-1907 death records show that 33 children aged 12 or younger died over the course of the year.[25] Haywardites certainly knew that the epidemic was hitting the area hard, and they had clearly been told by the town physicians to maintain strict quarantines. By 1902, enough of the locals understood germ theory well enough to infer that quarantines would protect their children. Haywardites continued non-compliance, though, and the quarantine was not effective. Scarlet fever was certainly dangerous, and its epidemic nature ensured that waves of the disease regularly would kill a number of Hayward's children. The disease was considered to be a typical childhood disease, however, and so Haywardites considered it a sort of rite of passage. A quarantine might prevent infection this month or maybe even this year, but there was no quarantine that would protect that child forever.

The precautions against scarlet fever, for physicians in the early 1900s, were inadequate, but the precautions those physicians could take against another epidemic disease, smallpox, were superior. Vaccination, the preventative to smallpox that was nearly 100% effective, had been widely available in America since 1801, when imported to New York from Great Britain.[26] Even though it was successful in preventing this dreaded disease, however, turn-of-the-century Haywardites resisted vaccination, as did Americans in many other areas of the country.

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[25] "Pre-1907 Wisconsin Deaths," WHS. Trowbridge underreported those numbers to the SBOH. For October, November, and December of 1902, he reported 9 infections and 1 death; pre-1907 death records clearly show 4 deaths for those three months.

[26] Judith Walzer Leavitt, "'Be Safe. Be Sure.': New York City's Experience with Epidemic Smallpox," in *Sickness & Health in America*, ed. Judith Walzer Leavitt and Ronald Numbers (Madison: The University of Wisconsin Press, 1997), 411.

Smallpox was a disease that occurred in regular epidemic waves throughout the country, beginning with the first European landings and spreading quickly through the Native American populations that had no natural immunity. After an incubation period of one to two weeks, victims of the disease experienced a high fever and a headache, followed by a rash that soon erupted into spots. These spots "evolved from flat to raised pimples, finally blistering into oozing pustules." In addition to causing the skin eruptions, the smallpox virus "ravaged inside the body, attacking the throat, lungs, heart, liver, and intestines." Smallpox that erupted into facial lesions had a 25% mortality rate; when the virus did not erupt into facial lesions, it carried a 70% mortality rate. Survivors carried life-long immunity, but those who had the facial lesions were permanently disfigured.[27]

As terrible as this disease was, it had a preventative that was nearly 100% effective. Before 1720, American physicians could only institute quarantines in the hope that the disease would not spread. In 1721, a preventative that had been "long used in Africa and Asia," variolation, was introduced in Boston. Variolation involved inoculation of a healthy person with the substance from the pustule of a person with an active case of smallpox. The procedure produced a mild case of smallpox, which was usually survived, and the sickness, like a naturally acquired case, produced life-long immunity. Variolated patients, however, were contagious and could spread the genuine disease among unvariolated contacts. Variolation in Boston in 1721 was, in fact, the likely cause of a 1731 smallpox epidemic in New York.[28] Thus, the cure, ironically,

[27] *Ibid*., 410; *Stedman's*, s.v. "smallpox."

[28] Leavitt, "'Be Safe. Be Sure,'" 410.

caused the disease and so carried the reputation of being dangerous into the 1800s, when a much less hazardous therapy replaced variolation.

Vaccination, like variolation, involved the introduction of a foreign substance into the body. This no longer was active smallpox virus but instead was a variation of the virus: cowpox. When done correctly, the cowpox vaccination provided life-long immunity to smallpox. When done incorrectly, especially when needles were shared or the supply of cowpox was contaminated, the vaccination could introduce other diseases to the patient, such as syphilis. And, vaccination supplies could lose effectiveness if not periodically fortified with fresh cowpox virus; thus, vaccinated people could still develop smallpox when exposed to active cases.[29]

Because of the cultural memory of the problems with variolation and the difficulties with vaccination, a strong anti-vaccination movement developed throughout the United States. In addition, "antivaccinationists spoke directly to a concern that all citizens, and especially immigrant groups, harbored about violations of personal liberty." In sum, those opposed to vaccination for all these reasons presented a terrible obstacle to physicians who had the preventative to this disease but who were often unable to employ it. Antivaccinationists in New York, for example, were able to prevent the city's board of health from mandatory vaccinations during an epidemic in 1893 and 1894.[30]

A similar movement sprang up in Milwaukee in 1894, leading to riots in the southeastern part of the state. Fourteen years earlier, in 1880, the SBOH had noted in its annual report that vaccination ought to be made "compulsory" in order to avoid general

[29] *Ibid*., 411.

[30] *Ibid*.

panic and a depletion of vaccination supplies when an epidemic approached. This requirement would be difficult to enforce, however, as the SBOH noted that many Wisconsinites, "especially … those of European birth," were "by no means ready to accept this conclusion," and the "community as a whole [was] not yet prepared for direct legislation for this purpose."[31]

The SBOH's concern was well-founded. In early 1894, the SBOH responded to an increase in the number of reported small-pox cases by ordering all children in the state to be vaccinated by February 20th of that year; children who were "not holding a certificate of vaccination from a regular practicing physician" by that date were prohibited from attending school.[32] Within a week, an "Anti-Vaccination movement" had sprung up in Milwaukee, a city with a large population of German and Polish immigrants. The movement was a union of those who believed that vaccinations were designed only to enrich doctors, those who feared the vaccination would cause the disease, and a fair number of anti-statists – people, especially those from "private and church schools," who did "not care about the theory or practice of vaccination but [were] unduly jealous of any interference or semplance [sic] of interference on the part of the state."[33]

Vaccination troubles persisted in general throughout the state and, in particular, in Milwaukee for a long time afterwards. In November, eleven months later, health officials attempting to treat a smallpox patient made an effort to remove him from his house, but

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[31] 5th *SBOHR*.

[32] *HR*, 8 February 1894.

[33] *Superior Telegram* reported in *HR*, 15 February 1894.

they were confronted by a mob, including one Milwaukeean who was "armed with an ax." The ax-bearer swung his weapon several times at one of the health officers, who was lucky enough to be able to escape injury.[34] Ten years later, the SBOH continued to report that it "frequently hear[d] that vaccination is simply a creation of the medical profession in order to obtain a small fee for performing the simple operation."[35]

Physicians in Hayward reported fewer problems enforcing vaccination standards, despite the fact that almost half the population was of European birth. While Milwaukee rioted in February 1894, Hayward reportedly complied with the SBOH order. Within two weeks of the order, "most everybody here [had] been vaccinated," which, according to the editor of the *Republican*, "was the proper thing to do."[36] Following the quarantine orders during scarlet fever epidemics would have also been the proper thing to do, yet Haywardites resisted quarantine and complied with vaccination, despite the practice's reputation for causing collateral damage. Perhaps the fact that vaccination did not carry a corresponding detrimental effect on household finances or that it was a demonstrated disease preventative caused greater compliance. Or, perhaps compliance was driven by the perception that smallpox was not a typical childhood malady. Whatever the reasoning behind Haywardites' willingness to be vaccinated, physicians' reports of compliance are supported by the fact that very few deaths due to smallpox can be found in the pre-1907 death records.[37]

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[34] *HR*, 1 November 1894.

[35] 20th *SBOHR*, 6.

[36] *HR*, 22 February 1894.

[37] Generally, although the pre-1907 death records are incomplete and were updated only sporadically, they appear to be more reliable than the reports that the health officer sent to the SBOH.

Despite vaccination efforts, smallpox epidemics continued throughout the state and especially in many areas of the north, due in large part to continual migration through the area. The SBOH vaccination orders applied to school-age children, while immigration was typically a movement of young adults. And as the lumber camps in northern Wisconsin were full of immigrant laborers, they were a major source of contagion. In December 1894, smallpox broke out in a lumber camp near Rhinelander, in the north-central part of the state.[38] In January 1895, newspapers throughout the state reported that a "smallpox detention hospital" in Manitowoc had been robbed; an unsuspecting family had bought the stolen furniture and bedding, "supposing them to be new," and smallpox had since appeared in the household.[39] In February 1895, the disease was reported to be "king" in Minneapolis, only a few hours from Hayward via railroad.[40] In July 1895, "the smallpox situation" progressed "to such a state that the matter of burning the lumber camps" in northwest Wisconsin was "laid before the governor" and the SBOH.[41] In effect, the epidemics spread almost as quickly as the rumors of epidemics had spread.

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[38] *HR*, 20 December 1894.

[39] *HR*, 17 January 1895.

[40] *HR*, 8 February 1900.

[41] *HR*, 25 July 1901. Compared to the possibility that an individual camp would actually be infected with smallpox and spread that infection, there would have been a greater threat to northern Wisconsin from the burning of that camp. Cutover lands filled with sawdust, discarded branches, and pine needles usually surrounded logging camps. A small fire in this type of area was capable of quickly becoming an uncontrollable disaster. Small fires in eastern Wisconsin, for example, rapidly spread on October 8 and 9, 1871 – the same day as the Great Chicago Fire – and became a major disaster for an area that was about twice the size of the entire state of Rhode Island. Twelve towns, including Peshtigo, WI burned to the ground during the firestorm, which had walls of flames reportedly 90 to 100 feet high. An estimated 1,500 people died in that fire. Fires in cutover lands were constant threats. Wyman, *The Wisconsin Frontier*, 245.

Smallpox in lumber camps could not easily be isolated; a burgeoning epidemic in a camp was likely to spread quickly. In January 1902, the editor of the *Enterprise* commented on the rumors that there was a major smallpox epidemic in Hayward, purportedly afflicting "over a hundred" of the locals. The rumors, editor Schei claimed, were unfounded. Reporting on his conversations with the local doctors, Schei claimed the city was "free from the dread disease" and "there is no likelihood that it will reach the city."[42] Three weeks later, however, Dr. Trowbridge had put four smallpox patients from a local lumber camp into the "pest house."[43] And only a week later, the government doctor, Davidson, reported that there were "several cases of small pox" at LCO.[44] Almost a decade later, in March 1911, a lumber camp on the south side of the LCO reservation was struck with the disease, and its population of ninety-five workers was quarantined. Despite the quarantine, the population on the LCO was affected, and smallpox was "having quite a run both among the Indians and whites."[45]

A reported epidemic usually prompted quick action, sometimes without legitimate grounds. Debating the effectiveness of vaccination and the sources of contagion in 1908, Dr. Cox related an incident at a lumber camp that could have been disastrous, had initial reports been correct. A camp near Cameron called Cox to treat close to two dozen cases of suspected smallpox. Cox found, however, that his "smallpox patients" were suffering from 'Lumbermen's Itch.' The doctor "advised the extermination of the pet of the

[42] *HE*, 15 January 1902.

[43] *HR*, 6 February 1902.

[44] *HR*, 13 February 1902.

[45] *SCR*, 2 March 1911.

'Lumber Jack', known as the great American gray black or camp louse, and the boiling of all clothing in a strong solution of lime and lye. A generous application of plain carbolized sulphur ointment," Cox claimed, "resulted in the recovery of all cases and the suppression of the smallpox scare."[46]

In general, Hayward's doctors agreed that vaccination was the best weapon in the fight against smallpox. Discussing his experiences with the disease in 1908, Dr. Trowbridge maintained that over the previous few years he had "seen over two hundred cases of smallpox." Of that number, only two patients had been vaccinated, "one of those thirty-five years before" and the other "probably was not thoroughly vaccinated."[47] Even during epidemics, the doctors continued to push for vaccination. During a minor epidemic in June 1910, Hayward's doctors urged "wherever the disease is suspected and those who are likely to come in contact with it should report for vaccination."[48] When a local high school student contracted the disease in 1911, the attending doctor warned "all students [to] take the precaution of being vaccinated."[49]

In addition to vaccination, the doctors advocated, and the health officers enforced, quarantine followed by fumigation. Hayward had a "pest house," an isolation hospital meant to keep the sources of contagion far from the general population. Originally, the isolation hospital was about two miles north of the city, but it was moved when the Hayward Indian School was built on the site in 1901. Local physician Dr. Grafton had

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[46] Joseph P. Cox, M.D., "Variola: Facts Regarding Absolute Immunity by Vaccination," *WMJ* 6, no. 10 (1908), 562-3. Cameron is in southern Sawyer County.

[47] *Ibid.*, 573.

[48] *SCR*, 16 June 1910.

[49] *SCR*, 9 November 1911.

put some "mild cases" in isolation at this new pest house under the care of a local practical nurse.[50] When another "smallpox scare" erupted in late 1914, patients with both smallpox and chickenpox were "quarantined in order to prevent a spread of the contagion."[51]

Further prompting Haywardites' compliance with the vaccination and quarantine orders was the city's proximity to known centers of smallpox epidemics, including both the lumber camps and the LCO reservation. Simply following the progress of epidemics, local doctors were able to determine that both areas represented sources of contagion. And, they could see the positive effect of vaccination, quarantine, and fumigation. Some cases seemed to erupt spontaneously, however, and their source was a cause for debate. By 1908, Dr. Cox ably discounted the idea that "smallpox is a disease of filth," arguing that "before the days of vaccination we found it thriving just as prolific in the aseptic home of the millionaire as in the humblest hamlet of the poorest mendicant."[52] Another idea was that the housefly spread smallpox along with typhoid fever, diphtheria, and scarlet fever; one Wisconsin paper asserted that "when small-pox last visited Milwaukee a number of cases of the disease were attributed to the mischeivous [sic] activity of the flies."[53] More likely, however, was the hidden carrier, traveling into town from an area that was a typical source of contagion. During Sawyer County's mini-epidemic in summer 1910, the generally accepted theory was that the disease was "brought into town

[50] *SCR*, 9 June 1910.

[51] *HR*, 3 December 1914.

[52] "Variola," 562-3.

[53] *SCR*, 29 September 1907.

either from some logging camp or from a log drive" and that the carriers "developed" their disease at a local hotel quietly, avoiding detection by the local health officer.[54] Not surprisingly, local doctors urged that all cases be reported, whether they were verified or only suspected. At the end of an epidemic in 1914, the local paper emphasized that "in order to stamp out contagious diseases it is necessary for the people to cooperate in unison with the city health board."[55]

Scarlet fever and smallpox both were recognized epidemic diseases at the turn of the century. Their contagious nature was, on a basic level, recognized and understood. Therefore, preventative vaccinations and defensive quarantines could be, and were, endorsed by local physicians as necessary and by the local board of health as legally required. The community's – and America's – late 19th century experience with tuberculosis was, however, a literal frontier. It was a disease with a new identification requiring a new type of treatment that was publicly presented as being modern and uniquely American. Ultimately, the campaign against TB that appealed to voluntary efforts to confront the disease was as successful as any strategy could have been in the era before antibiotics.

Before 1882, tuberculosis, or consumption, was understood as a disease that was constitutional, hereditary, and frequently chronic. Victims were typically young adults, although children could develop and die from the illness, and frequently, entire families would fall to the disease. Once visibly afflicted with tuberculosis, a patient might develop a "quick" or galloping case. More often, the patient would waste away, leading

[54] *SCR*, 16 June 1910.

[55] *HR*, 3 December 1914.

to the label "consumption," for the body appeared to slowly consume itself. Physicians, believing the disease was inevitable for family members of consumptive patients, had few remedies to suggest. Among the most accepted remedies were fresh air, exercise, sunshine, and good food and water.[56] Because treatments were ineffective, a sense of fatalism developed about consumption, which, together with the age of the typical victim, tended to encourage a rather romantic view of the disease itself. Consumptives were, in short, individuals requiring sympathy and tenderness.

In 1882, the image of tuberculosis underwent a ground-shaking transformation. Robert Koch, a German bacteriologist, announced his discovery of the tubercle bacillus that year.[57] This discovery meant that consumption was not hereditary, nor was it untreatable. If one could avoid the bacillus, one could avoid the disease. And, if physicians could destroy the bacillus, their patients would recover.

Although the discovery of the tubercle bacillus was ground shaking, changes were slow to arrive for the physicians who treated consumptives or for the consumptives themselves. Until the development of chemotherapies, mortality rates essentially remained the same, as did the treatments that physicians employed. One aspect of the disease that changed was its fatalistic character: the idea that physicians were on the brink of discovering a way to end the disease led to hope. The other facet of the disease that almost immediately changed was identification: physicians could identify who carried the tubercle bacillus. This identification allowed for – in some instances – early treatment, which tended to be more effective, and it allowed for modification of

[56] *PMA*, 497-510.

[57] *Mycobacterium tuberculosis* See Chapter 4.

behaviors that further spread contagion. Identification also allowed for the removal of the patient to a rapidly developing system of sanatoria, thus removing the source of contagion from families and reducing the "hereditary" aspect of the disease. In short, although mortality rates did not drastically change, morbidity rates dropped. Diagnosis and treatment, however, remained problematic. The lack of confidence that the general public had in scientific medicine at the end of the 19th century along with the well-publicized dearth of effective treatments led many newly diagnosed consumptives to seek out alternative practitioners, many of whom prescribed treatments that did more harm than good.[58]

While the discovery of the tubercle bacillus immediately made waves in the European and American medical community, the translation of the idea of consumptive communicability to the general public, especially in frontier Hayward, was much more gradual and was dependent upon the public's acceptance of the germ theory of disease causation (see Chapter 4). A full decade after Koch's discovery, in 1893, a typical Hayward consumptive, such as Mrs. Jonas Anderson, was depicted in the local papers much as he or she would have been described elsewhere twenty years earlier. Mrs. Anderson fell ill when she was quite young, was surrounded by family members who

[58] For more on the history of tuberculosis in America, see: David L. Ellison, *Healing Tuberculosis in the Woods: Medicine and Science at the End of the Nineteenth Century* (Westport, CT: Greenwood Press, 1994); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge: Harvard UniversityPress, 1996); Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994); and Richard Harrison Shryock, *National Tuberculosis Association, 1904-1954: A Study of the Voluntary Health Movement in the United States* (New York: Arno Press, 1977). For more on the history of tuberculosis in Europe, see: David S. Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (Berkeley: University of California Press, 1995); Thomas Dormandy, *The White Death: A History of Tuberculosis* (New York: New York University Press, 2000); and F.B. Smith, *The Retreat of Tuberculosis, 1850-1950* (London: Croom Helm, 1988).

also suffered from this "hereditary" disease, wasted away over a matter of years, attempted to cure her illness through exercise and exposure to fresh air and sunshine, and experienced a particularly tender and sympathetic death. Shortly after their marriage, the Andersons' household expanded by one when Jonas' 17-year-old sister Ingrid moved in. Both of the Anderson women were ill with consumption; Mrs. Anderson was confined to her bed in late August 1893, and Ingrid was reported to be improving from "several hemorrhages" in late September of the same year. Mrs. Anderson's sister, Lizzie McCarty was also "numbered among the sick" frequently in 1894, during the final days of Mrs. Anderson's life.[59]

Mrs. Anderson's fight against the disease was based on the idea that fresh air and exercise would be effective in recreating individual vitality. Less than two months before she died, her husband "built a bowery by his hotel" where she "pass[ed] many pleasant hours during the day." Exposure to fresh air was supposed to be an effective cure, so the reported consequence of the "many pleasant hours" spent in the bowery was, unsurprisingly, that "her condition for the better [was] quite noticeable."[60] When she was able to exercise, she did so. Her obituary praised "her heroic efforts for restoration to health by walking and riding," but she died "in spite of all that loving hands and hearts could do, and in spite of medical skill." At only 25, she was "[j]ust in the bloom of womanhood," and "[d]oubtless the future to her looked fair."[61] Her sister Lizzie

[59] *HR*, 14 August; 28 September 1893; 21 June 1894.

[60] *HR*, 14 June 1894.

[61] Obituary, *HR*, 2 August 1894.

continued to suffer consumptive episodes through the next two years, and Mrs. Anderson's sister-in-law, Ingrid, died from the disease in 1896 at the young age of 23.[62]

The Anderson and McCarty families' experience with tuberculosis was mirrored in many other Hayward households. In March 1895, 13-year-old Mamie Lamott fell to consumption, only a year after her father passed from the same illness.[63] The Phelan family, in particular, suffered from multi-generational experiences with consumption. Parents Richard and Ann frequently fell ill, as did their sons Tommy and Peter. And Peter's wife died from the disease in 1900.

The tuberculosis mortality rate in Hayward and the surrounding countryside was quite high. Between January 1, 1905 and September 30, 1906, Sawyer County had the fourth highest death rate from tuberculosis in the state, only trailing behind the heavily populated and immigrant-packed Milwaukee, LaCrosse, and Racine counties.[64] And, in 1910, the *Sawyer County Record* [hereafter *SCR*] reported that the TB death rate in the county was 22.48 per 10,000, "the highest of any county in the state."[65]

The SBOH, in its fight against TB, promoted multiple pieces of legislation to the state government as well as to local governments. In 1903, the SBOH endorsed a bill establishing a state-supported sanitarium, which would cost an estimated $100,000 and an additional $1,000 per month.[66] From the viewpoint of mainstream physicians like Dr.

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[62] *HR*, 21 June 1895; 23, 30 January; 30 July 1896.

[63] Obituary, *HR*, 4 April 1895.

[64] 21st *SBOHR*, Table 104.

[65] *SCR*, 10 November 1910.

[66] "News Items," *WMJ* 1, no. 2 (1903), 197. The act was signed June 13, 1905.

Cox, treatment at a sanitarium had multiple benefits. The patient would be given regimented treatment, thus allowing for the best chance of recovery. That treatment would be managed by licensed physicians rather than by alternative practitioners. And, the patient would no longer present the danger of communicability to his or her family members. Dr. Cox asserted, in a paper presented to the SMS, that such treatment "would reduce the mortality of tuberculosis at least one-fourth."[67] Commitment to the sanitarium could be either voluntary or involuntary.

In 1906, the SBOH recommended that local governments pass "Anti-Spitting Ordinances" and helpfully provided those governments skeleton forms, which would standardize the laws. Local officials only had to fill in their city's name.[68] Based on the assumption that bovine tuberculosis had a direct relationship with human tuberculosis, the SBOH decided to carry its crusade to the dairy industry in 1908 and began a sponsorship of legislation to require tuberculin tests of all dairy cows. And, in 1910, the SBOH "passed a rule forbidding the use of public drinking cups in schools and on trains."[69]

The SBOH considered its steps in the fight against consumption to be essential, and it was able to acquire legislative support in that fight. Haywardites, however, treated the legislation with a "we'll see" attitude. When notices appeared in the Chicago, St. Paul, Minneapolis & Omaha railroad station and in the local post office regarding anti-spitting ordinances, the *SCR* observed that this "should appeal to the common sense of

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[67] Cox, "General Practice in Northern Wisconsin," 645.

[68] 21st *SBOHR*.

[69] *SCR*, 18 February 1909; 10 February 1910.

everyone and be generally adopted in Hayward."[70] The paper continued to publicize the anti-spitting notices, cajoling its readers to follow the rules. Tuberculine testing of dairy cows was required, but Haywardites continued to allow their animals to wander freely, thus potentially exposing them. In 1910, cows remained "a common sight about the streets, mussing sidewalks, …. [and] playing mischief generally." In addition, the animals were often seen "picking over refuse from a store that had been put into a barrel at night for burning, … drinking in the gutters on the main street, and drinking out of the sewer creek."[71] Even the editor of the *SCR* argued that while "there is a real danger from bovine tuberculosis, … the laws against it should not be fanatical." In an attempt to find some sort of "temperate sense" regarding "fads, scares and fanatical waves of all kinds," the state's tuberculin test law would be challenged by dairy men from Waukesha County all the way to the US Supreme Court, if necessary.[72] When the SBOH abolished the common drinking cup in 1910, the Hayward school board "installed a drinking fountain in the High school, *to try it.*"[73]

When Sawyer County's mortality rate rose to the highest in the state, it became clear that the SBOH efforts were having little effect. The *SCR* bemoaned the mortality rate, arguing that "Hayward, the county seat and most populous village has done nothing" in the fight against the disease when compared to work done in other localities. Instead, Haywardites would "denounce outlaws and murder, and [yet] in the next breath express

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[70] "A Suggestion for Adoption," *SCR*, 4 February 1909.

[71] *SCR*, 20 January 1910.

[72] *SCR*, 9 February 1911. Waukesha County is in the southeastern part of the state.

[73] *SCR*, 3 March 1910. Emphasis added.

… sympathy for some flower of the community who are [sic] heroically struggling against the disease" that the community, in "shameful negligence," was "doing nothing to stop."[74] Although the community had passed a law against spitting, for example, "the steps and walk in front of the public library and stores, and at the post office corner as well as the interiors of some of the places [were] frequently so foul from spitting that they [were] a positive disgrace to the town."[75]

The locals were not alone in their resistance to what seemed to be "fads, scares, and fanatical waves." Members of the city and county government and Hayward's health officers resisted the state's directives in what appeared to be useless data collection. In 1913, the SBOH criticized the inaccurate reporting many local boards of health had regarding tuberculosis. Sawyer County had, for many years, reported TB deaths to the SBOH but no TB cases. For the entire year of 1913, for example, Sawyer had 12 deaths but no cases to report, and in the previous 7 years, the county reported 34 deaths but, again, no cases.[76] In all these years, however, Sawyer reported no new cases of TB whatsoever. In its 1914 report, the SBOH reminded Wisconsinites that the state legislature had passed a law requiring physicians, boarding house and hotel owners, and employees and operators of "each and every public or private institution, or dispensary" to report every case of tuberculosis of which they were aware. Clearly responding to physicians who questioned this law based on the right to individual liberties, the SBOH reminded physicians that they had been granted exclusive license to practice medicine by

[74] *SCR*, 10 November 1910.

[75] *SCR*, 19 October 1911.

[76] 1912, 13 deaths; 1911, 11 deaths; 1910, 6 deaths; 1909, 4 deaths; from 1906 to 1908, no deaths at all. 22nd – 24th *SBOHRs*.

that same legislature.[77] In return, the SBOH argued, "the state has the right to demand something in return."[78] The SBOH made a supplementary effort to obtain TB information pursuant to its special TB report; although Sawyer county had reported no cases that year along side its 12 deaths, the county physician[s] who responded to the survey still only reported 5 cases, all of them women.[79] The following year, 1914, Sawyer reported 4 cases and 10 deaths, 2 deaths and no cases in 1915, and 6 deaths and no cases in both 1916 and 1917. Dr. Fred Johnson, Deputy State Health Officer of the Fourth District, in a report covering Sawyer County between November 1913 and July 1914, gave a limited explanation for the insufficient statistics. He asserted that it was difficult to "get statistics from the Indians, where tuberculosis is very prevalent" and further that "many of them live off the reservations and in most unhygienic surroundings."[80]

In 1908, the fight against consumption began to turn a corner. Instead of relying solely on SBOH legislation that focused on identifying bovine carriers and restricting human communicability, the battle would be waged by the volunteer Wisconsin Anti-Tuberculosis Association (WATA). The WATA initiated a public relations campaign, designed to increase awareness as well as to raise money through contributions rather

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[77] Physicians questioned "the right of the public by legislative enactments to require that this be done." 25th *SBOHR*, "Special Report on Tuberculosis," 96-97.

[78] *Ibid*.

[79] 25th *SBOHR*, "Special Report on Tuberculosis," Table 16, 101. The SBOH sent questionnaires to 2,600 physicians in the state, but only 716 (about 28%) completed the survey. Of those physicians that returned the survey, 304 (about 42%) "reported that they had no cases under their care at that time and that they knew of no positive cases of tuberculosis in the community." (98)

[80] 25th *SBOHR*, 188.

than through taxation. This campaign initially centered on the Christmas stamp sale; stamps bearing the slogan "Stamp out the white plague" would be sold in various businesses for "one cent each to raise funds for … the fight against consumption."[81] Buyers were, through their purchases, accepting a financial role in the fight against TB; when they affixed those stamps next to the US Post Office's stamps on all their Christmas card envelopes, the stamp buyers were advertising their supportive role. Only a week after the 1909 stamps first went on sale in Hayward, the *SCR* reported that sales records "show[ed] that the people of Hayward and Sawyer county [were] in full sympathy with the grand, world wide effort to stamp out the awful disease."[82]

Overall, Haywardites supported the dairymen of Waukesha County in their legal challenge to bovine tuberculin testing, and they continued to spit on the post office floor. And, the community's doctors resisted conforming to state law regarding the reporting of statistics about the epidemic. But, the community at large literally bought into the struggle when it was put up for sale. In 1911, the US Post Office announced that it would no longer accept mail with the white plague stamp; the Post Office was afraid that the additional stamp was confusing to a public that might not understand that mail continued to require regular postage stamps. By November, the Post Office had backed down from the new policy, due to a national public outcry.[83]

In addition to the Christmas stamp, the National Anti-Tuberculosis Association (NATA) instituted a second annual event designed to increase awareness and

[81] *SCR*, 25 November 25; 2 December 1909.

[82] *SCR*, 16 December 1909.

[83] *SCR*, 30 November 1911.

understanding regarding the disease. For the event, "Tuberculosis Sunday," the NATA urged "every minister in every city, town, village and hamlet in the United States [to] adopt as his text … the gospel of pure air, pure food and pure living." NATA, along with state and local boards of health, provided participating churches with "literature against the white plague."[84] In the first year, NATA estimated that 40,000 sermons were preached nationally on this gospel of the white plague. The following year, NATA calculated that the number of sermons on the subject would reach 200,000.[85] The third year of the campaign featured two Tuberculosis Sundays, one in April and the second in October. The *SCR* reported that local ministers "doubtless" would "join in the movement and deliver addresses on the … gospel of health."[86] The October edition of TB Sunday focused on revealing and reproving "fraudulent and alleged 'cures' for consumption" and was supported by NATA-produced literature.[87] The ministers who participated in these TB Sundays preached a message of salvation, exposed false prophets, and distributed copies of this gospel of health.

A third line of attack on TB led by the WATA was likely more entertaining for individual Haywardites. The organization provided traveling orators who gave free lectures regarding "the tuberculosis question and the work" of the WATA. In January 1912, Harvey Dee Brown, "general lecturer of the association," announced that he would be making a presentation in Hayward. Brown said that he would "try to cover the entire

[84] *SCR*, 3 March 1910.

[85] *SCR*, 2 February 1911.

[86] *SCR*, 14 March 1912.

[87] *SCR*, 17 October 1912.

tuberculosis problem in a popular way using about 75 stereopticon lantern slides," a method in which "ordinarily great interest [was] shown."[88] A presentation like this before the advent of radio and in a small town like Hayward, especially when given in the dead of winter when there is little else happening, would certainly generate "great interest." However, Brown's lecture, although "both very interesting and instructive," was not well attended; the *SCR* speculated that this was because of the "severe cold," a condition that would not have been so prohibitive in other areas of the state in which Brown had likely given earlier lectures.[89]

While the lecture in Hayward was not well attended, similar lectures that focused on the fight against TB and other endemic diseases were quite successful across the country. This was especially true in rural areas, where a lecture accompanied by visual aids provided the best – and likely only – entertainment available to folks with few opportunities for distraction.[90] In the 1910s, the physicians and field matrons assigned to the Hayward Indian School frequently traveled to the LCO to give similar presentations to the Ojibwe regarding tuberculosis and trachoma as well as guidelines for personal cleanliness.[91] These talks were usually well attended, in all probability because of the slides and visual aids as well as the communal nature of the meetings.

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[88] *SCR,* 11 January 1912.

[89] *SCR,* 19 January 1912.

[90] For a parallel in the fight against hookworm in the American South, see John Ettling, *The Germ of Laziness: Rockefeller Philanthropy and Public Health in the New South* (Cambridge: Harvard University Press, 1981).

[91] "Narrative Reports," in *United States OIA.*

The success of the WATA and NATA efforts in the late 1900s and early 1910s, especially in frontier Hayward and Sawyer County reveals the willingness of Americans to join in endeavors that were voluntary, especially when they had a consumerist or entertainment value. Raising funds for disease research and awareness of disease susceptibility or communicability is certainly less effective at controlling morbidity and mortality during epidemics, when compared to quarantines and vaccinations. Haywardites certainly understood this difference; when they bought their Christmas stamp, they knew they were not preventing infection among their family members. However, the act of buying the stamp and pasting it to the envelope was uncompelled and participatory. Haywardites were partaking in a communal activity when they watched the "magic lantern" slide shows. The same Haywardites who resisted prohibitions against spitting on the railway station floor and the steps to the post office were quite willing to spit on the back of a Christmas stamp. The distinction between the two activities, for Haywardites, was a restriction of personal liberties versus a voluntary effort towards a participatory goal, and while the first was entirely unsatisfactory, the second was enjoyable.

CHAPTER SIX:
HEALTH AND THE MANAGED ENVIRONMENT

> "If we are surrounded by civilized conditions, we must adjust ourselves to such conditions, and not attempt by violent means to attain adjustment to the environment of the cave man."[1]
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> "I have known a patient who had never slept with a window raised, on the third day after gradual introduction to the open porch, when the temperature was twenty degrees below, complain of suffocation when brought into the warm room and ask to be again taken into the delicious atmosphere out-of-doors. Last winter my own patients actually enjoyed 38 below and grew fat."[2]
>
> "White man – he funny man – Tell Indian 'go in house.' Indian live in house. Indian get consumption. White man tell Indian 'Live outdoors.' White man – he funny man."[3]

In January 1898, 65-year-old NWLC Superintendent Capt. C.E. Rogers and his wife traveled to Battle Creek, Michigan in order to receive treatments for his ill health.[4] (Fig. 6.3) The Civil War veteran of Second Bull Run, Antietam, Fredericksburg, Chancellorsville, and Gettysburg was understood, by his friends, to be suffering from "overwork and exposure brought on by being too ambitious" in his work at the lumber company.[5] This was not the first time that the Rogers had traveled in the search for better health, nor would it be the last such trip they would take. Only three months earlier they

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[1] "Summer Health Hints," *SCR*, 25 July 1912.

[2] Thos. H. Hay, M.D., "Treatment of Consumption from a Sanatorium Viewpoint," *WMJ* 6, no. 11 (1908), 626.

[3] *Milwaukee Journal*, 21 October 1923, quoted in "The Odanah Indian Clinic" in *WPA Indian Research Project Collection, 1936-1940*, ed. Macaria Murphy (Milwaukee: Marquette University Department of Special Collections and University Archives, 1983).

[4] *HR*, 20 January 1898.

[5] *HR*, 19 August 1897; 20 January 1898; Obituary, 3 May 1900.

had spent several weeks at Round Lake Park Place, and about six months after returning from Michigan, they began treatments at a hospital in Eau Claire.[6] After his trips, the local newspaper usually reported that the Captain's health had improved. He "gained health" at Round Lake and "had a good time as well." He was "feeling better than he has for some time" after the trip to Michigan.[7] And after he began treatments in Eau Claire, the paper optimistically reported that the Captain was "partially recovered" and "looking well."[8]

Privately, Captain Rogers' friends and family knew that the situation was much more serious. The Rogers stayed in Battle Creek longer than they expected, and although he came home much improved, he was not in good health.[9] In mid-June, the Captain drank a full two-thirds of a glass of turpentine, unable to discern the taste – or smell – of turpentine from the taste of the mineral water that he had been drinking regularly since the trip to Battle Creek.[10] By July 1898, Captain Rogers submitted to a first operation in Eau Claire.[11] After a second operation in February 1899, Eau Claire physician J.V.R. Lyman reported that "this time" he had successfully removed the Captain's troublesome prostate, and although it was not cancerous, the Captain would "always have to be careful

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[6] *HR*, 2 September 1897. Round Lake Park Place was a resort at Round Lake, a small community near Hayward.

[7] *HR*, 10 March 1898.

[8] *HR*, 25 August 1898.

[9] *HR*, 24 February 1898.

[10] *HR*, 23 June 1898.

[11] Stanley Edwards Lathrop, *A Brief Memorial Tribute to Captain Clayton E. Rogers: Born, April 4, 1833, Died April 20, 1900* (Ashland, WI: S.E. Lathrop, 1900.

regarding" his health.[12] Only a year after the apparently successful operation, Captain Rogers had to submit to a third operation. He died only a few weeks later, on April 30, 1900 in the Eau Claire hospital, never having returned home after that last operation.[13] At great expense, Captain Rogers had traveled great distances, seeking the right combination of physician, atmosphere, water, and diet that would assist in the recovery of his health.

In the mid-1800s, Americans who were ill and who had the resources to do so often traveled to places that were described as "healthy" – that is, they traveled to areas that had the reputation of not breeding illness. Americans who did not want to move permanently, like Captain Rogers, took short trips in order to benefit from "healthy" environments long enough to recover. For Americans seeking a permanent change in atmosphere, an "unhealthy" environment, especially in the growing and dirty cities in the East, was added to the list of reasons for emigration to the clean and open west, while an apparent "healthy" environment became an immigration pull for new settlements. Most migrants to the American frontier did not move solely in the search for better health, but the desire for a health-producing environment often influenced the final decision for migration.[14] Certainly, Hayward's boosters were aware of this line of reasoning, so they

[12] Letter from JV Lyman to R.L. McCormick, Esq., 2/22/1899, North Wisconsin Lumber Company (Hayward, Wis.), "Records, 1883-1901," WHS Library.

[13] Lathrop, *A Brief Memorial Tribute*.

[14] John E. Baur, "The Health Seeker in the Westward Movement, 1830-1900," *The Mississippi Valley Historical Review* 46, no. 1 (1959), 91. Consumptives were the exception, as they typically sought the thin atmosphere of Colorado or the dry heat of Arizona as a last effort for recovery; consumptives who recovered in their new surroundings tended to remain, as they believed the environment was essential to their continued recuperation. For more on the American correlation between location and health, see: Timothy Todd Bawden, "Reinventing the Frontier: Tourism, Nature, and Environmental Change in Northern Wisconsin, 1880-1930" (Dissertation, University of Wisconsin, 2001); Jane B. Donegan, *Hydropathic Highway to Health*; Robin A. Kearns, and Wilbert M. Gesler, ed., *Putting Health into Place:*

advertised their community to potential migrants as being one that would produce better health.

The advent of germ theory in the late 1800s began to change Americans' health travels. Increasingly, Americans understood illness as not being the product of an unfortunately situated combination of atmosphere and water. Instead, they recognized that elements within the atmosphere and water could be altered in order to eliminate the creators of illness.[15] And with the arrival of progressive faith in the wisdom of science and the prudence of good government, Americans began to believe that they could change the external environment as well as individual internal physical structures in order to create bountiful health. Fewer Americans traveled for health, instead choosing to cope with environmental issues in their own communities; those who continued to travel did so because they sought particular physicians or clinics that were reputed to have special skills or resources to repair those internal physical structures. Haywardites' actions reflected this overall national trend. While early residents of Sawyer County clearly understood their environment as a resource containing both cures and poisons, by the 1910s, they recognized the environment as a resource that could be managed in order to produce better health. This new understanding of the environment as malleable was clearly influenced by the general acceptance of germ theory as well as by Progressive Era cooperation between science, education, and the government.

Landscape, Identity, and Well-Being (Syracuse, NY: Syracuse University Press, 1998); Ott, *Fevered Lives: Tuberculosis in American Culture since 1870*; and Valenčius, *Health of the Country.*

[15] Baur, "The Health Seeker in the Westward Movement, 1830-1900," 109.

For many years, Hayward's boosters had insisted that the city was uniquely "healthy," and thus, the area would be good for settlement. In 1883, when the settlement was established, boosters announced:

> The water is clear, cool and pure and the running streams are fed by springs many of which are mildly impregnated with iron, sulphur and other valuable medicinal properties. … The climate is bracing and healthy, without summer heat and dust and modified in winter by forests of virgin pine, maple, birch and elm.[16]

The village, in fact, was built around one of those "medicinal" springs; a small creek named Bradley Brook ran through the center of town and on to the Namakagon River. Early Haywardites used Bradley Brook as an open sewer, a fact that boosters used to further promote the settlement. They claimed that "Hayward is the healthiest village on the line of the North Wis. Railway because its site is sloping towards the river and the waters of Bradley Brook running through the village make a sewer that man's ingenuity cannot rival."[17] This type of self-promotion continued well into the 1890s. In 1895, the editor of the *Republican* asserted that "Northern Wisconsin is blessed with one of the healthiest climates in the world," and in 1896 he argued that "Sawyer county is one of the healthiest counties in Wisconsin."[18] As late as 1913, a state booster asserted that the

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[16] *NWN,* 13 July 1883.

[17] *NWN,* 2 May 1885. The sewage that went to Bradley Brook and eventually to the Namakagon was raw. According to Hayward historian, Eldon Marple, the NWLC diverted the flow from Bradley Brook to its lumber storage pond (now Lake Hayward), "except for enough to move the sewage" downriver. Marple "Visitor" 8/11/84 "Ba-Ke-la – The Creek With Two Mouths" 12. Theoretically, it is possible that the diversion to the NWLC pond was also "downriver" from some of the raw sewage inlets. It is no wonder, then, that Haywardites struggled with water-borne illnesses (see Chapter 4).

[18] *HR,* 31 January 1895; 2 July 1896.

wilderness "climate of upper Wisconsin is … promotive of vigor in human, animal and plant life."[19]

Despite the boosterism, early Haywardites did not hesitate to emigrate in order to find healthier climates and environments, as long as they could afford the move. In May, 1902, NWLC executive W.H. Guy decided that his troublesome case of tuberculosis would respond to a change of climate, so he and his wife moved to Denver where he "hope[d] to recover fully." The same month the Guys moved to Denver, another Haywardite troubled with tuberculosis, E.R. Sherburn also decided to take the "western" cure; he moved to Calgary, Canada.[20] Generally, Haywardites who moved to urban areas were drawn there by medical facilities or physicians with prominent reputations; other "health migrants" moved to destinations that were understood to be remote or frontier areas. It is clear that, for these migrants, the frontier and its wilderness environment was beneficial and represented a potential source of better health, as opposed to the manmade environment, which was likely to be harmful.

Other Haywardites, like Captain Rogers, maintained their homes in Sawyer County and only traveled to restore previous good health. In July 1899, county clerk Otto Christianson, for example, traveled to Hot Springs, Arkansas to take an extended course of treatments for "rheumatism" at the baths there.[21] (Fig. 6.2) It was not unheard of for the Christianson family to travel in order to find medical relief. The first Mrs. Christianson, for example, had traveled to Minneapolis to receive treatments for her

[19] Campbell, A.D., Manager Wisconsin Advancement Association, *HR*, 2 October 1913.

[20] *HE*, 7 May 1902.

[21] *HR*, 2 July 1899.

health problems.[22] When his adopted daughter needed to see a doctor in April 1898, Otto took her to St. Paul, and he traveled there again when his third daughter, Augusta, needed an operation.[23] This trip to Arkansas, however, represented a more sizeable commitment. The journey was longer, the course of treatment was extended, and the venture was more expensive. Above all, Otto was leaving behind two small children and a second wife, who was pregnant with his third child.[24]

The decision to make this extended trip was likely influenced by two conditions. First, Otto had been struggling with his "rheumatism" for a long time.[25] In May 1896, he had begun to have bouts of illness that had caused him to be "laid up for several days" at a time.[26] By spring, 1898, his illness was "severe," and it only worsened as the months passed.[27] By the next spring, the actions of a good friend influenced Otto's decision to commit a great deal of time and resources to the recovery of his health. John England "of the logging firm of England & Shea" was himself at Hot Springs for treatment "for a

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[22] *HR*, 1, 8 August 1895. The first Mrs. Christianson was a Norwegian immigrant, Ingeborg Olstad, who had immigrated directly to Hayward in 1886. After an illness that lasted for at least 2 ½ years, she died on January 21, 1897 of consumption, only a month from her 36th birthday; she was survived by her parents, siblings, Otto, and their adopted daughter. *HR*, 7 June; 20 December 1894; 10 January; 3 October 1895; 19 November 1896; Obituary, 28 January 1897.

[23] *HR*, 7 April 1898; 21 March 1900.

[24] Otto's third child, Augusta Christine, was born on 18 September 1899, only a few weeks after Otto returned from Arkansas. *HR*, 7, 21 September 1899.

[25] Publicly, Otto's early troubles were assigned to either rheumatism or the "grippe." His death in 1904 was listed as being caused by tuberculosis, the same disease that killed his first wife. However, the death records state that his tuberculosis had lasted for two years, while Otto had been ill for at least eight. The length of his illness, the symptoms that imitated rheumatism, the open sores that he suffered (he had a "painful felon" on his finger that warranted a newspaper notice in the *HR*, 15 September 1898), the eye troubles his natural children suffered, and the inability of his first wife to bear children all point to syphilis. See: Allan M. Brandt, *No Magic Bullet*.

[26] *HR*, 21 May 1896.

[27] *HR*, 5, 12 May; 15 September 1898.

difficulty that he contracted" that spring. England had become enamored with the baths, claiming that "any person afflicted with chronic trouble will receive more benefit from taking baths than from any other source or treatment." On this trip, England was accompanied by his wife; she ended up staying in Hot Springs for two weeks after he returned to Hayward.[28]

Otto was no less captivated with Hot Springs and the baths. In a lengthy letter he sent to the *Republican* only two weeks after his arrival, Otto reported:

> I have now taken 16 bath [sic] and am glad to tell you that I am already feeling a good deal better. I have felt the rheumatism moving around just like as if it were hunting for a place to get out. Last Thursday I felt very bad with pain, and it was all I could do to walk 3 blocks to the bath-house, but after I had taken the bath the pain left me and I have not felt much of it since. I tell you … this water is a wonderful thing and nearly every constitutional disease to which human flesh is heir, is benefited here, not a week passes but some remarkable cures are effect. [sic] [29]

Under doctor's orders, Otto took a course of treatments that reflected hydrotherapeutic ideals. He drank half a gallon of "magnesia spring water" each day along with a "whole lot of Uncle Sam's hot water which is free for everybody, out of the Fountain of Life where there is a lot of people all day drinking."[30] Along with drinking great quantities of the water, Otto took the baths. He wrote that the bathhouses were supplied

> by gravity with the hot water from the springs on the mountain above, the distribution being made under the immediate supervision of a superintendent appointed by the United State [sic] Government, which has also established rigid directions and regulations for the use of the baths so a poor man can bath [sic] as well as a rich man, the charges are from $3.00

[28] *HR*, 10 August 1899.

[29] *HR*, 17 August 1899.

[30] Otto did not miss a chance to make some money, even while he was taking the cure. He wrote that the magnesia water "is something like Kuriko that I have for sale in Hayward, it is good for everything, and especially for stomach, liver and kidney troubles." *HR*, 17 August 1899.

> to $10.00 a course, for twenty-one baths, according to the class of accommodations furnished by the bath house selected. … The Government has also a bath house that is free of charge for all poor people, and the manager informed me that there were sometimes as many as 600 people there bathing at one time, and it is estimated that about 50,000 people come here every year and take baths…[31]

In other words, the water that was providing such a wonderful health benefit for Otto, John England, and 50,000 other people was bountifully provided by nature and equitably distributed by the American government. Such a wonderful natural resource was rightfully available to rich and poor man alike.[32]

When Otto returned to Hayward after his treatments were complete, he claimed that he was "fully restored to his old time robust health." Certainly, he was more active after he returned. He traveled to Oregon in December where he "expect[ed] to locate a piece of pine land for future use." In January 1900, he traveled with a group of Hayward's leading men across the state to Antigo to bring home another Haywardite, Dan McQuarry, who had become dangerously ill. And in May, he worked on some home and office improvements, including the purchase of a new roll-top desk and a new garden and "terrace in front of his residence." By June, though, Otto's "rheumatism" had returned. He attempted another cure in January 1904, this time traveling only to Eau Claire, where he "expect[ed] to undergo an operation." Hopes for a cure, this time, were tempered. "His many friends" in Hayward were optimistic that he would "be much benefited by the operation and … return well or at least greatly improved." Otto had to

[31] *Ibid*.

[32] For more on Hot Springs, Arkansas, see Valenčius, *Health of the Country*.

return to Eau Claire for a second operation, but by the first week of October 1904, the 39-year-old Otto was dead.[33]

Although Haywardites still believed that a change of environment could cure those who were ill, the doctors who treated them did not necessarily agree. In 1905, Dr. Cox argued that the climate in Northern Wisconsin certainly was not "too rigorous" for tuberculosis patients; in fact, it was "superior to [the climate of] Colorado, Arizona, or New Mexico."[34] And by 1908, Wisconsin doctors were repeating to their patients what they were being told - that "practically pure air is to be had everywhere." One needs only to modify the house to bring that "air to the patient." This might require the removal of windows or walls. Ideally, the house should have a "porch system … which is open on two sides" and which adjoins to either "a small dressing or sitting room." As for the environment that would best effect a cure, "the ideal climate does not exist."[35]

Proper ventilation had long been recommended as a preventative for consumption as well as for illnesses in general. Readers of the *Advisor* had learned in the 1870s that "the walls of a building should be so constructed as to admit air between the exterior and interior surfaces otherwise the interior of the house will be damp and unwholesome."[36] Steele's physiology students read that men were "more frequently bald than women" because of "the effect of the close, unventilated head-covering commonly worn by

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[33] *HR*, 7 September; 7 December 1899; 18 January; 3, 10, 31 May; 14 June 1900; 7 January 1903; 6 October 1904.

[34] Cox, "General Practice in Northern Wisconsin," 645.

[35] Hay, "Treatment of Consumption from a Sanatorium Viewpoint," 625-6.

[36] *PMA*, 227.

men."[37] They also learned that because public parks brought "fresh air, sunshine, green grass and trees within the reach of all," they were "truly the 'breathing-holes of a city.'"[38]

By the early 1910s, health researchers advocated "deliberate exposure to the sun, or heliotherapy" as well as proper ventilation in order to treat tuberculosis and rickets and to create a "general well-being."[39] Tuberculosis sanatoria were designed around the dual beliefs in the value of ventilation and sunshine, both of which had a minimizing effect on the presence of the bacteria that caused TB.[40] Thus, sanatoria were typically built with abundance of windows as well as with wide verandas and porches on which patients spent much of their waking – and sleeping – hours.[41] This trend quickly translated into home designs; new homes across the country and in Hayward were built with large sleeping porches and sunrooms. Existing buildings were adapted to the new model; teachers at Hayward's schools were instructed to keep the windows in their classrooms open as much as possible, despite the characteristically cold winter weather.[42] The

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[37] Steele, *Fourteen Weeks in Human Physiology*, 158.

[38] *Ibid*., 165. The Progressive Era park movement advocated the creation of urban parks to beautify cities whose decay was likely to increase poverty and generate crime. Park advocates maintained that the presence of nature within the cities would enhance the lives of poverty-stricken urban citizens. For more on the park movement, see: Robert Gottlieb, *Forcing the Spring: The Transformation of the American Environmental Movement* (Washington, DC: Island Press, 2005); Roy Rosenzweig and Elizabeth Blackmar, *The Park and the People: A History of Central Park* (Ithaca, NY: Cornell University Press, 1992); and William H. Wilson, *The City Beautiful Movement*, Creating the North American Landscape (Baltimore: Johns Hopkins University Press, 1989).

[39] Margaret Campbell, "What Tuberculosis Did for Modernism: The Influence of a Curative Environment on Modernist Design and Architecture," *Medical History* 49, no. 4 (2005), 464.

[40] Ventilation decreases the concentration of the bacteria. Benenson, 495.

[41] Campbell, "What Tuberculosis Did for Modernism," 465.

[42] For more on the alteration of the architecture of private homes in order to produce better health, see: Tomes, "Private Side of Public Health," 507. Tomes argues that "social historians have tended to treat the expressed concern about disease prevention as a rationalization for some other, more genuine, objective such as reinforcing gender roles, class differences, or ethnic prejudices. … This school of analysis assumes

assumptions that ventilation *cured* and that the lack of ventilation *caused* tuberculosis had become normalized by the mid 1910s; tuberculosis was known among all economic classes, but reformers tended to agree that its "greatest harvest [was] in the cellar homes, slums, tenements and crowded districts" that lacked ventilation and sunshine.[43] (Fig. 6.4)

In conjunction with fresh air and sunshine, Haywardites learned from progressive researchers that a truly healthy body required a healthy and balanced diet and cleansing eliminations of the digestive tract.[44] (Fig. 6.1) This idea was not new; in 1895, the NWLC store asserted that although its groceries were more expensive, "We are prepared to convince you that… Pure India Tea, Genuine Mocha and Java Coffee, Pure Cream of Tartar Baking Powder, Real Fruit Jams and Preserves Are the best, healthiest and cheapest in the end…"[45] Wisconsin progressives led the country in the passage of pure food legislation, which went into effect there on January 1, 1898.[46] However, enforcement of pure food laws in Hayward did not happen for many years. No local grocer or butcher was charged with a violation of the law until 1911, when grocer

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that the decision to install water closets and use disinfectants in the home had more to do with upholding the conventions of social class and of gender roles than it did with the desire to evade disease." However, one should not assume that the "desire to evade disease" was not the primary motivation for altering domestic architecture. People have historically taken extreme measures in order to avoid disease, and those measures tend to become increasingly radical as the fear of the potential disease intensifies. In this case, enduring exposure to the below-freezing temperatures of Northern Wisconsin in the dead of winter in order to avoid tuberculosis seems reasonable.

[43] "Tuberculosis in Wisconsin on the Decline, says Alvin C. Riese," *HR*, 21 May 1914.

[44] For more on progressives and a healthy diet, see: Rima D. Apple, *Vitamania: Vitamins in American Culture*, (New Brunswick, NJ: Rutgers University Press, 1996); Suellen Hoy, *Chasing Dirt: The American Pursuit of Cleanliness* (New York: Oxford University Press, 1995); Charles E. Rosenberg, ed., *Right Living: An Anglo-American Tradition of Self-Help Medicine and Hygiene* (Baltimore: Johns Hopkins University Press, 2003); Tomes, *Gospel of Germs*; and James C. Whorton, *Inner Hygiene: Constipation and the Pursuit of Health in Modern Society* (Oxford: Oxford University Press, 2000).

[45] *HR*, 25 July 1895.

[46] *HR*, 6 January 1898.

William Biegler pled guilty to selling "food manufactured in unclean, unhealthful, unsanitary meat market, using tools in said market, unclean and unsafe."[47] Even after repeated violations, Biegler's market continued to thrive, perhaps because Haywardites viewed the prosecutions as state interference with normal business.

Pure food legislation, like the law that Biegler violated, represents a prototype of progressive reform. A problem, like the adulteration of food products, was identified and researched. When the consequences of the problem were recognized, the researchers presented their findings to legislators who wrote laws to prevent the problem from occurring. Historians of progressive era reform have tended to find the origins of the reform impulse in scientific advancements or the development of modern statecraft from about 1885 to 1920.[48] However, progressive pure food legislation and other reforms intended to improve some critical aspect of Americans' health may be part of a larger and much longer process. Historian Ruth Clifford Engs has argued that Americans tend to experience cycles of reform on average every eighty years. In the first part of the cycle, individual health crusaders promote education and social pressure in order to change Americans' individual habits. In the second part of the cycle, that education and social pressure translates into coercion through public policies. Americans either accept those

[47] Wisconsin, Municipal Court (Sawyer County), *Criminal Dockets, 1905-1961*, 13 October 1911. For his violation, Biegler was fined $25 plus court costs of $1.10.

[48] For more on the Progressive Era, see: Brandt, *No Magic Bullet*; John W. Chambers, *The Tyranny of Change: America in the Progressive Era, 1890-1920* (New York: St. Martin's, 1992); Michael McGerr, *A Fierce Discontent: The Rise and Fall of the Progressive Movement in America, 1870-1920* (New York: Free Press, 2003); Daniel T Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge, MA: Belknap Press of Harvard University Press, 1998); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: Harvard University Press, 1992); and David P. Thelen, *The New Citizenship: Origins of Progressivism in Wisconsin, 1885-1900* (Columbia, MO: University of Missouri Press, 1972).

"popular changes or reforms that make sense" or begin to resist the coercion, and finally, individuals become generally complacent about the issue.[49] Engs asserts that Progressive Era reformers tapped into that regular cycle of reform when they attempted to change Americans' diet and exercise habits.

Whether the general impulse to improve Americans' health began in the 1880s or was only part of a recurrent cycle of reform, the pure food impulse had roots older than the late 1890s. When Captain Rogers traveled to Battle Creek Sanitarium in Michigan in 1898, he encountered one of the most effective and persuasive centers of pure food reform in the nation. John Harvey Kellogg, M.D., a Seventh-day Adventist and vegetarian had become the medical superintendent of that sanitarium in 1876 and had rapidly transformed the institution into a national health-seekers' destination, "combining aspects of a European spa, hydrotherapy institution, and hospital."[50] The Battle Creek program included a "daily regimen [of] proper exercise, sensible clothing, sunshine, bathing, and rest" as well as a strict vegetarian diet and, at least for Captain Rogers, mineral water that smelled and tasted as bad as turpentine.[51]

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[49] Ruth Clifford Engs, *The Eugenics Movement: An Encyclopedia* (Westport, CT: Greenwood Press, 2005), 32. See also: Engs, *Clean Living Movements: American Cycles of Health Reform* (Westport, CT: Praeger Publishers, 2000); Harvey Green, *Fit for America: Health, Fitness, Sport, and American Society* (New York: Pantheon Books, 1986); William Gerald McLoughlin, *Revivals, Awakenings, and Reform: An Essay on Religion and Social Change in America, 1607-1977* (Chicago: University of Chicago Press, 1978); and James C. Whorton, *Crusaders for Fitness: The History of American Health Reformers* (Princeton, NJ: Princeton University Press, 1982).

[50] Engs, *The Eugenics Movement*, 135-6. For more on John Harvey Kellogg, see: T. Coraghessan Boyle, *The Road to Wellville* (New York: Viking, 1993); Gerald Carson, *Cornflake Crusade* (New York: Rinehart, 1957); John Money, *The Destroying Angel: Sex, Fitness & Food in the Legacy of Degeneracy Theory, Graham Crackers, Kellogg's Corn Flakes & American Health History* (Buffalo, NY: Prometheus Books, 1985); and Richard William Schwarz, *John Harvey Kellogg, M.D.* (Nashville, TN: Southern Publishing Association, 1970).

[51] Ruth Clifford Engs, *The Progressive Era's Health Reform Movement: A Historical Dictionary* (Westport, CT: Praeger Publishers, 2003), 192-3.

In 1914, Kellogg sponsored a national convention in Battle Creek attended by many leading national progressives and health reformers. The First National Conference on Race Betterment included progressive participants such as Jacob Riis and Booker T. Washington as well as Robert DeCourcy, the "conservative supporter of immigration restriction."[52] Among those attending the conference were supporters of euthenics, who argued that environmental reform was essential to social progress, and supporters of eugenics, who asserted that "if humankind were to improve, the parents of future generations would have to be carefully selected," as traits such as "intelligence, … patriotism, alcoholism, shiftlessness, pauperism, and a tendency to wander" were heritable.[53] Kellogg's Presidential Address called for reforms addressing both euthenic and eugenic issues; Kellogg appealed for the "elimination of tobacco [and] alcohol … through stricter laws," improvements in diet and physical fitness, and "the creation of a 'Eugenics Registry Office' … to establish a race of human thoroughbreds."[54]

One of the driving forces behind the Conference on Race Betterment was Charles Benedict Davenport, recipient of a Carnegie Institution grant and leader of the American

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[52] Steven Selden, *Inheriting Shame: The Story of Eugenics and Racism in America* (New York: Teachers College Press, 1999), 7.

[53] *Ibid*., xiv-1. For more on the history of eugenics, see: Edwin Black, *The War against the Weak: Eugenics and America's Campaign to Create a Master Race* (New York: Four Walls, Eight Windows, 2003); Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca, NY: Cornell University Press, 1997); Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (New York: Knopf, 1985); Wendy Kline, *Building a Better Race: Gender, Sexuality and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001); and Alexandra Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Berkeley: University of California Press, 2005).

[54] Selden, *Inheriting Shame*, 8-9; Engs, *The Eugenics Movement*, 73. According to Engs, "In the United States eugenics became an underlying theme in many health-reform crusades, including the prohibition, sexual purity, birth control, antiprostitution, pure food and drug, and anti-venereal disease campaigns of the Progressive Era." (xiv)

Breeders Association. Committees in this Association focused on, among other things, "the Heritability of Feeblemindedness; Insanity; Epilepsy; Criminality; Deaf-Mutism; Eye Defects; Genealogy; the Inheritance of Mental Traits; Immigration; and Sterilization and Other Means of Eliminating Defective Germ Plasm." In 1911, Davenport had published an extremely influential book, *Heredity in Relation to Eugenics*, which linked ideas of racial difference to modern social problems; Davenport's work was "cited by more than one-third of the high school biology textbooks used" in America between 1920 and 1940. And, Davenport's arguments certainly made their way into the themes of the First Conference on Race Betterment as well as into those of the Second Conference in 1915. At that second conference, the future co-author of *Applied Eugenics* (1922) argued that tuberculosis deaths were not caused by the tuberculosis bacterium but by poor heredity. [55]

As with legislation regarding pure food, Wisconsin progressives were ahead of the eugenics curve. Although legislation requiring "sterilization of mental defectives" was not enacted until 1913, committees of the Wisconsin state legislature introduced bills proposing such legislation as early as 1907. In 1927, the US Supreme Court upheld a similar statute in Virginia, after which numbers of sterilizations of "mental defectives" in Wisconsin increased; by January 1, 1936, Wisconsin performed more sterilizations than all but six other states.[56]

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[55] Selden, *Inheriting Shame*, 4-11. Address by Paul Popenoe.

[56] "Sterilization Legislative History" in Bernett O. Odegard, and George M. Keith, *A History of the State Board of Control of Wisconsin and the State Institutions 1849-1939* (Madison: Wisconsin State Board of Control, n.d.), 74.

At least publicly, Haywardites welcomed these developments in eugenic and euthenic thought. In 1911, the *SCR* began a series of articles, prompted by activities of progressive reformers in the Hayward school system. The editor of the *SCR* praised those reformers for teaching "good breeding" as part of the study of physiology. It was critical, the editor argued, that the schools initiate

> thorough physical training, including lectures by our physicians … to the end that healthy minds in healthy bodies may result and that our children, who are to be the parents of the next generation, be inspired with a desire for physical and moral as well as intellectual excellence, and be trained … for that responsibility which they must soon shoulder – the rearing of a higher type of American manhood and womanhood.[57]

After a prominent eugenicist gave a lecture to Hayward's teachers regarding heredity, the *SCR* asserted that tendencies were certainly inherited, and therefore, the "breeding up" of the American race was essential.[58] The principal of the Hayward schools began distribution of this information to his students within a week. His aim was to impress on the students the "importance of correct living, and to teach the fundamental facts which underlie the preservation of good health," as "inefficiency and ill health come not alone from defects in the human machine or from faulty care of it, but also from unfavorable environment," whether that environment was external or internal. Hayward's students were to become "familiar with the laws of personal hygiene" and to learn that it was the "duty of everyone to keep his body in the highest possible degree of health under all conditions."[59] By the time the Wisconsin legislature passed the eugenic sterilization law

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[57] "The Tendency of Advance Education – Civic Progress," *SCR*, 15 June 1911.

[58] *SCR*, 12 October 1911.

[59] *SCR*, 19 October 1911. The information that the principal distributed to his students included pieces on exercise and diet. The sixth bulletin addressed care of the teeth: "in order to have good strong teeth, resistant to decay, one must eat hard and coarse foods… Teeth and gums, says the bulletin, need exercise

in 1913, the public had been primed to accept its precepts. When the National Conferences on Race Betterment were held the following year, euthenics and eugenics – the competing ideas that environment or heredity determined social progress – were so intertwined in popular thought, at least in Hayward, that there was nothing new in Kellogg's presidential address.

As Wisconsin began to enact eugenics-based laws, Haywardites, in fact, tended to obey them, despite their historical tendency to flout restrictive legislation; this surprising level of compliance reflected a growing acceptance, even in this rural area, of the authority of the state as well as the fact that the population was increasingly trained and willing to accept the precepts of modern science. The laws that most directly affected residents of Hayward and Sawyer County were those that restricted marriage. Nationally, progressive reformers promoted legislation that prohibited marriage when one or both partners were determined to be affected by "venereal diseases, especially syphilis, that could be passed down to unborn children." In most cases, this legislation required medical examinations and a "marriage health certificate" that specified the absence of venereal disease.[60] Wisconsin's eugenics marriage law went into effect on January, 1914, and by April, Haywardites were producing the required certificate in order to get married.[61]

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as much as any other part of the body. … The teeth, through exercise were well formed and strengthened, the gums were hardened, and it was easy to preserve the teeth with very little care." *SCR*, 18 April 1912.

[60] Engs, *The Eugenics Movement*, 53.

[61] "First Eugenics Marriage Performed in Sawyer County," *HR*, 2 April 1914; "Eugenics Law Scores Another Victory in Hayward," *HR*, 9 April 1914. In order to get the required certificate, the groom had to undergo a medical exam, which, for the first marriage, took thirty minutes and cost $3.00.

Progressive health reformers recognized from experience with earlier attempts at reform, especially regarding vaccines and quarantines (see Chapter 5), that voluntary efforts would be more successful than coercion. Consequently, at the First Conference on Race Betterment, Kellogg called for voluntary initiatives regarding childrearing.[62] Preeminent among these was the Better Babies Movement, a progressive public health plan that was designed to "educate parents in adequate child care, hygiene, and sanitation" with the goal of improving "children's health and prevent[ing] racial degeneracy."[63] In 1915, the federal Children's Bureau sponsored a "'Better Babies Week,' during which American mothers were encouraged to have their children weighed and measured."[64] Progressive reformers on the local level throughout the country promoted "better baby clinics," at which parents could receive free medical checkups for their children. And, parents could bring their babies to county and state fairs to participate in Better Baby Contests. Contestant babies were measured against each other in multiple ways, including physical and intellectual growth as well on as family routines. The "Better Babies Standard Score Card" that was used for these contests, for example, asked for the baby's physical measurements, such as height and weight, as well as the extent of the baby's vocabulary. It also asked questions about the baby's sleeping habits:

[62] Engs, *The Eugenics Movement*, 73.

[63] *Ibid*., 19; See also Marilyn Irvin Holt, *Linoleum, Better Babies, and the Modern Farm Woman, 1890-1930* (Albuquerque: University of New Mexico Press, 1995).

[64] Engs, *The Eugenics Movement*, 20.

"Does child sleep alone? Does child sleep in open air, with open windows or with windows closed?"[65]

Parents of Better Baby Contestants were no doubt surprised to find out that fat babies were not necessarily "Better Babies." For many years, Hayward's newspapers had lauded the births of new Haywardites with announcements regarding their hefty weight. Ed Collett, for example, became the "proud and happy parent of a 16 pound girl" on July 10, 1894.[66] In February 1900 – only two months before he died – Captain Rogers had a new 12 ¼ pound grandson.[67] Otto Christianson's first son was "a very timid lad" who weighed "but 11 pounds" at birth.[68] And in June 1904, H.W. Brooks reported "the arrival of a 20-pound girl at his house."[69] There is no official record stating that these children actually weighed what was reported; it is quite likely that there was plenty of exaggeration involved in this boasting. Nevertheless, it is clear that Haywardites valued size as a measure of a baby's vitality and healthiness. In short, "well-fed was synonymous with healthy." For families living in a near-subsistence frontier economy, "fat represented sparing no expense to feed the little one," and thus, it had been a very public sign of wealth.[70] Better Baby Scorecards, however, indicated that fat on babies was less a marker of healthiness than it was a sign of overindulgence. Families of those

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[65] "Better Babies Standard Score Card" (1913) reprinted in Annette K. Vance Dorey, *Better Baby Contests: The Scientific Quest for Perfect Childhood Health in the Early Twentieth Century* (Jefferson, NC: McFarland & Company, Inc., 1999).

[66] *HR*, 12 July 1894.

[67] *HR*, 22 February 1900.

[68] *HR*, 12 September 1901.

[69] *HR*, 23 June 1904.

[70] Dorey, *Better Baby Contests*, 151-2.

Better Baby contestants were being told it was a very public sign of a poorly managed environment.

Despite lingering beliefs that fat babies were healthy babies, Haywardites were becoming convinced that perhaps the progressive health care reformers were correct. After all, the reformers had scorecards, contests, and the apparent consensus of modern "scientific" thinkers, like John Kellogg and Charles Davenport. And the idea that the internal environment was malleable and that it unmistakably affected that particular individual's ability to resist disease seemed reasonable. This made sense; it was a way to make germ theory and humoral theory work together. If you kept your humors in balance, the germs would be less likely to attack.

By the 1910s, Haywardites who sought health were less likely to leave town, not because Hayward was considered any healthier than in the past or because it was considered a frontier wilderness in which *nature* provided health. Instead, the health seekers no longer bothered to leave because they had a growing faith in *their* ability to manage their own internal and physical environment in order to produce health. Haywardites continued to visit the spas in Hot Springs, AR and Battle Creek, MI, but their travels were no longer based on the idea that health is attached to particular physical environments.

Fig. 6.1
Postmark is 12/30/1905[71]

[71] "Sanitarium, Battle Creek, Mich.," (J. Murray Jordan: Philadelphia) n.d. Postcard from author's collection.

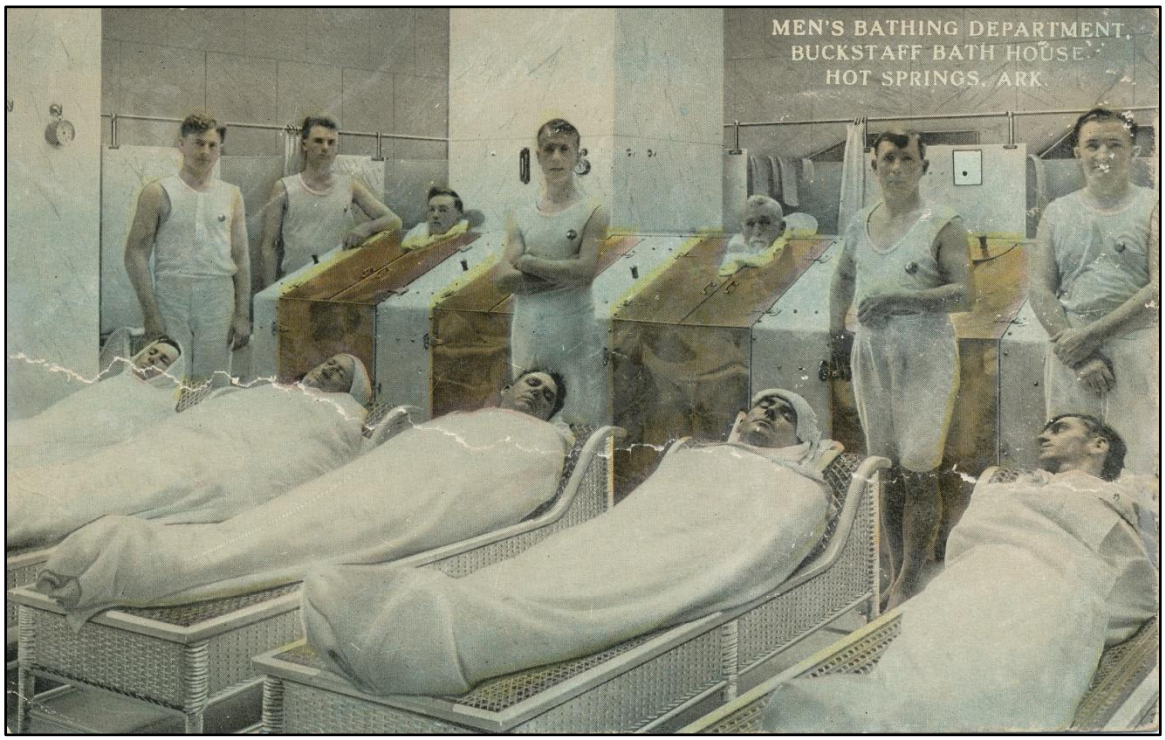

Fig. 6.2
Taking in "Uncle Sam's free water."[72]

[72] "Men's Bathing Department, Buckstaff Bath House, Hot Springs, Ark.," (F.C. Boving: Hot Springs, AR) n.d. Postcard from author's collection.

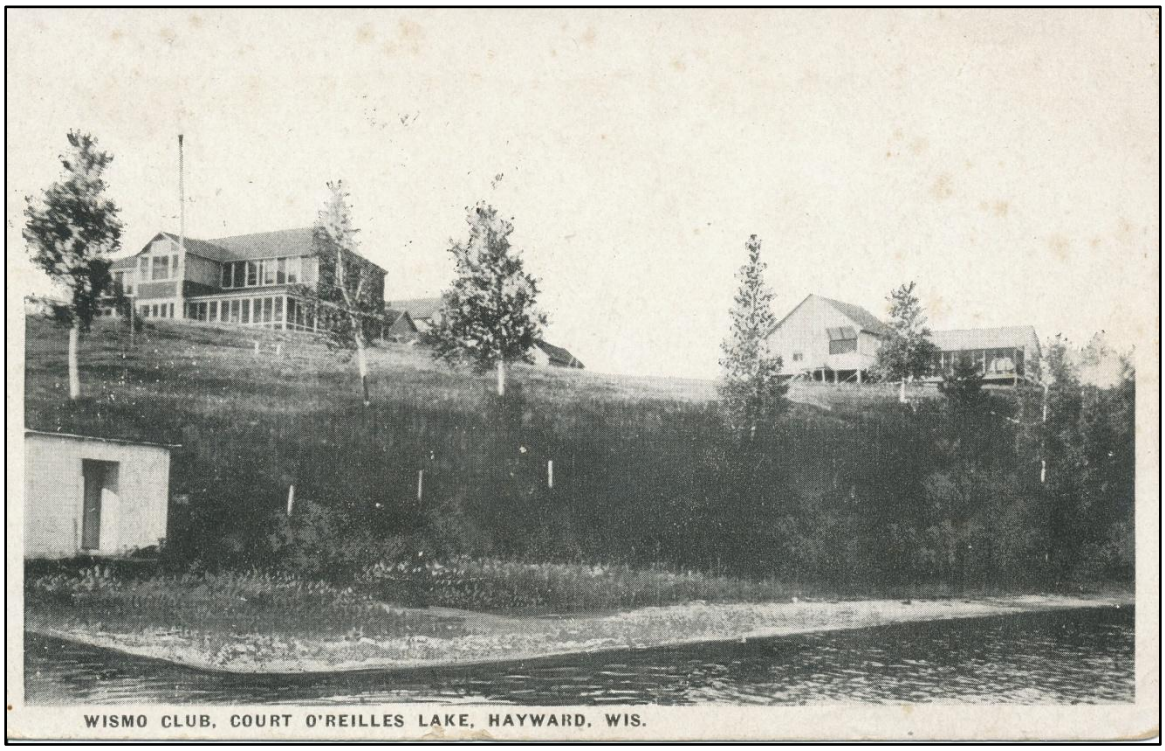

Fig. 6.3
Note the large, screened-in porches designed to take advantage of the fresh air and sunshine. Postmark is 7/6/1925.[73]

[73] "Wismo Club, Cort O'Reilles [sic] Lake, Hayward, Wis.," (The *illegible* Company, Post Cards: Minneapolis) n.d. Postcard from author's collection.

Fig. 6.4
"Cascarets Candy Cathartic – Best for the Bowels"[74]

[74] *HR*, 26 April 1900.

CHAPTER SEVEN:
A CITIZEN'S RIGHTS:
PUBLIC HEALTH AT THE HAYWARD INDIAN SCHOOL

> "As we follow the story from Missionary to Mission school, U.S. Government day school or Boarding school … I unhesitatingly [advocate] Non-Reservation Indian Boarding schools as the best channel for the young Indian to develop into citizenship." [1]

> "The teachers of the state can do much to develop a sentiment in favor of such laws, regulations, and practices as will make possible the building up of men and women with strong and healthy bodies. … The first thing to consider in the teaching of physiology and hygiene is the sanitary condition of the school room and surroundings."[2]

The arrival of the Spanish influenza in the fall of 1918 tested Wisconsin's public health care system and revealed both the successes and the failures of the reformers who had worked so diligently to reform that structure. Compared to other states, Wisconsin was relatively well prepared to confront this pandemic efficiently and effectively as it had long established procedures, on both the state and local levels, to respond to health crises. The SBOH, now over forty years old, had "unusually broad powers, allowing it to impose statewide quarantines unilaterally in times of public health emergencies as well as to issue 'rules and regulations for the protection of the public health.'" Not even ten years after the SBOH was created, the Wisconsin legislature had the foresight to require the creation of local boards of health, each of which would carry out the demands of the SBOH as well as "serve as liaison" between the state agency and the local government.

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[1] R.L. McCormick, *Evolution of Indian Education: Mission-Public School, U.S. Auspices in Sawyer County, Wisconsin* (Hayward, Wisconsin: 1901), 8.

[2] C.P. Cary, *Manual of the Elementary Course of Study for the Common Schools of Wisconsin*, 14th ed. (Madison, Wis.: Democrat Printing Co., 1910), 265.

When the flu arrived, then, state and local government agencies were configured in a way that would bypass much of the confusion and panic that this emergency could have created.[3]

The pages of the SBOH reports record the state agency's success in dealing with the emergency. According to SBOH statistics, the death rate from influenza per 100,000 Wisconsin residents in 1918 was 279.3, well below the national death rate of 298.9. Sawyer County's official rate, at 308, was much higher than the state rate, but it still was respectable, compared to national figures.[4] (Table 2) The statistics, however, do not tell the complete truth. Perpetually hidden within the official statistics and story, Wisconsin's Ojibwe population does not fit into this story of relative success. A small and relatively recently created pocket of the Ojibwe population that lived less than two miles from Hayward, in particular, did not fit into the SBOH's narrative, nor was it included in the official statistics. This community of 225 Ojibwe children, in particular, suffered a death rate of 3,111.1 per 100,000, more than ten times the already high Sawyer County rate.[5] The Office of Indian Affairs and local Haywardites were optimistic about this new little community when it was created; it was to be a model of modern government efficiency. As the unofficial statistics reveal, it became a model of bureaucratic incompetence.

In 1889, Congress enacted legislation that created an OIA office which would be dedicated towards Indian education; the new administrator of that office, the Indian

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[3] Steven Burg, "Wisconsin and the Great Spanish Flu Epidemic of 1918," *Wisconsin Magazine of History*, no. Autumn (2000), 41.

[4] 28th *SBOHR*, 53-57.

[5] *SCR*, 28 November 1918.

Schools Superintendent, promptly created a "comprehensive schooling system for American Indians and brought into that system … children in unprecedented numbers."[6] These children would generally board at OIA schools, often far from their families and tribes. During their schooling, the students would be immersed in Euro-American civilization, and after graduation, they were supposed to return to their tribes as ambassadors of that new way of life. Their subsequent presence in the tribe would hasten the economic and social changes that the General Allotment Act of 1887 had been intended to create.[7] Not least among the changes that the graduates were supposed to have developed were habits of health and faith in the emerging system of modern western medicine. Education in "right living" and in the development of a "sound constitution" would ideally present the graduates and their family members with "the beginning of the end of the old unwholesome living" and a "chance to stem the tide of inherited disease."[8]

Theoretically, this education in "right living" would be efficient as well as beneficial. The OIA had a medical department up until 1877, when the agency found its financial resources lacking and closed the department. After the closure, medical services provided by the OIA were provided through "agency and school doctors." The relationship between health care and education was further strengthened in 1909, when the OIA's new "medical supervisor …. was again placed in the educational division."[9]

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[6] Wilbert H. Ahern, "An Experiment Aborted: Returned Indian Students in the Indian School Service, 1881-1908," *Ethnohistory* 44, no. 2 (1997), 267.

[7] *Ibid*., 266.

[8] Dr. Martha M. Waldron, "The Indian School in Relation to Health," *The Sanitarian, a Monthly Magazine Devoted to the Preservation of Health, Mental and Physical Culture* 37 (1896), 304, 310.

[9] S. Lyman Tyler, *A History of Indian Policy* (Washington, D.C.: United States Department of the Interior, Bureau of Indian Affairs, 1973), 107.

While Indian children were boarding at the OIA schools, then, they learned about "right living" while they had direct access to the medical care that would ensure that inherited and acquired diseases were identified and treated. The situation was a recipe for government efficiency.

Children from the LCO, however, had difficulties accessing institutions in which these new lessons would be taught. In the late 1800s, northern Wisconsin Ojibwe had few local education alternatives that also provided critical social services. The LCO mission school, operated by the School Sisters of St. Francis, provided only one meal per day and had limited facilities for boarding. Another mission school operated out of Odanah, but that school was crowded with boarders. Public school systems in northwestern Wisconsin rarely accepted Native American children, and those schools did not provide meals or boarding. The Carlisle Indian Industrial School was a non-local option that some LCO parents considered, but attendance at Carlisle required a trip to Pennsylvania, which was no small feat in the late 1800s. And, once children left for Carlisle, they rarely returned before the completion of their schooling. The two Mishler boys, for example, left for Carlisle in late 1895, and they did not return to their families for eighteen months.[10]

In January 1893, the OIA opened the Tomah Indian Industrial School in Tomah, Wisconsin, about 200 miles from Hayward. Like other OIA boarding schools, the Tomah School was intended to encourage young Native Americans to adopt the practices of

[10] *HR*, 1897. Nationally, by 1900 the OIA school system was sizeable and included: 25 large boarding schools; 81 smaller on-reservation boarding schools; 147 reservation day schools that lacked boarding capacity; 32 government-funded private schools; and 22 schools run by missions. Francis Paul Prucha, "America's Indians and the Federal Government, 1900 to 2000," *Wisconsin Magazine of History* 84, no. 2 (2000-2001), 29.

white civilization while they abandoned the traditional culture of their tribes, all in the hope that these young people would grow to acquire full American citizenship.[11] Within two years, the school was crowded with children from many tribes across Wisconsin, including Winnebago as well as Ojibwe. In late August 1895, the *Republican* reported that sixteen children from the LCO had been taken on the trip to Tomah. Two weeks later, the paper noted that "another consignment of fifteen or twenty little Indian children were forwarded" to the boarding school.[12] LCO parents who watched their children being "forwarded" to Tomah were assured that in this quest for full American citizenship, the children would receive healthcare and be "housed, fed, and partly clothed by the government."[13]

When the children who had traveled to Tomah, Odanah, and Carlisle returned home from their months and years at the various OIA and mission boarding schools, LCO parents learned that the quest for citizenship had included an informal education in less than respectable "extracurricular" subjects. There were rumors that the older boys studying at Carlisle frequently left their dormitories at night to stay in "bad houses." And, at least one Ojibwe boy from a neighboring reservation claimed to have "slept with" LCO girls while they all boarded at Carlisle.[14] Girls who had attended the school at Tomah told stories of seeing the superintendent there engaging in inappropriate behavior with the students. Even the teachers at Tomah reported that some employees conducted

[11] "Tomah Indian School: A Model Institution of its Kind in Every Way," *Milwaukee Sentinel*, 22 July, 1894.

[12] *HR*, 22 August; 5 September 1895.

[13] *Relief to Indians in Wisconsin* (Madison, WI: Wisconsin Public Welfare Department, 1937), 11.

[14] Rev. Odoric to Stephan, illegible December 1898, *BCIM General Correspondence*, ser. 1-1, reel 27.

themselves improperly; in one instance, for example, a male employee was found hiding – and naked – in a female student's room.[15] Despite OIA and progressive reformers' assertions that government-directed education and healthcare would lead Native American children to "the beginning of the end of the old unwholesome living" and a "chance to stem the tide of inherited disease," it appeared that conditions at many of the Indian Schools were creating circumstances that reinforced that "old unwholesome living."[16]

In 1899, the OIA presented LCO parents with a new, and supposedly more attractive, option for educating their children. A boarding school was to be built a little over a mile north of Hayward on land that had previously served as the Sawyer County poor farm.[17] The children and their school superintendent, teachers, and janitors would live together as one, rather large family at a facility that would be large and modern; students would have all the benefits of steam heat, gas lighting, indoor plumbing, and modern "needle baths."[18] While attending the school, the children would learn reading, writing, and arithmetic as well as vocational skills. They would have access to a resident nurse and physician as well as to up to date hospital facilities, should they fall ill. And, LCO parents assumed that the fact that the children were relatively close to home meant that those children could visit home during weekends, holidays, and family emergencies.

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[15] Affadavit, Rev. Odoric to Stephan, illegible December 1898, *BCIM General Correspondence*, ser. 1-1, reel 27.

[16] Waldron, "The Indian School in Relation to Health,"304, 310.

[17] The poor farm was a "home" where relief could be given to indigents; it also was where Haywardites with serious contagious diseases were quarantined.

[18] McCormick, *Evolution of Indian Education*, 53. A needle bath was essentially a modern shower, except the water was forcefully sprayed from multiple directions.

The Hayward Boarding School soon became home to several hundred children from Ojibwe reservations throughout northern Wisconsin, and school officials set out to train their young charges in the ways of American civilization. (Figs. 7.1-7.2)

Bureaucrats at the OIA had a clear vision of the doctrine of modern healthcare that would be taught and practiced at all schools within the system. Included in this vision were expectations regarding public health – that is, the federally funded presence of professional practitioners, modern facilities, and up-to-date pharmaceuticals. Implementation of the vision at the Hayward school was problematic, however, partly because of the educators' restrictive notions of race but more importantly because of breakdowns in the OIA bureaucracy. Overall, this particular early venture into federally funded public health failed because of misguided assumptions. Progressive bureaucrats, both on the local and national level, assumed that adequate government funding of a healthcare system would naturally lead to increased standards and continuity of care as well as to better health among the Ojibwe children and their families. The bureaucrats did not take into account cultural notions of appropriate healthcare, nor did they understand that the success of their initiatives depended upon individuals who had no stake in improving the health of the Ojibwe. After two decades of federally funded healthcare, the Ojibwe children living at the Hayward Indian School were no healthier than their Anglo counterparts who lived in Hayward and who relied on the privately funded healthcare system.

When the Hayward school opened to students on September 2, 1901, it was indeed a large and modern facility. Located on 640 acres of land that was "well timbered with a growth of white, jack, and Norway pines," the school was situated so that students

had a pleasant view of a small lake as well as several dozen acres of farmland. The dormitories – one for the girls and one for the boys – were two-story brick buildings with stone foundations, as were the schoolhouse and mess hall. These buildings were all connected to a modern water and sewer system; each dormitory had a tub, five "needle baths," and toilets in the basement. The water that supplied the students' needs was "pure and soft," coming from a new pump house that sat on a 36 foot deep well. Finally, all of these structures had ventilation and steam heating systems.[19] In addition to these newly built and costly buildings, the school complex included several older frame buildings that had served as the county poor farm; these were to be used as agricultural buildings and as the isolation hospital.[20]

Large as it was, the school was not large enough to accommodate the number of children in the region. Originally built with a 130-student capacity, the school was soon enlarged, and by 1910, average attendance was over capacity at 227.[21] Despite the early expansion, the school remained overcrowded, and local superintendents continually requested more funding for facility expansion in OIA annual reports. In 1910, the superintendent asserted, "the school needs room… [for it] has never been properly equipped with room and facilities to do the best work. The capacity of the dormitories

[19] "Each of the four main buildings has a steam heating plant, using the American cast iron sectional boiler." *Ibid*., 53.

[20] *Statistics of Indian Tribes, Agencies, and Schools, 1903*, ed. Bureau of Indian Affairs (Washington: Government Printing Office, 1903), 43-44. Construction of the school cost an estimated $60,000. *HR*, 27 July 1899.

[21] *Ibid*.; "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA*, 5. In 1920, enrollment was 296, while capacity remained at 210. "Statistical Reports: 1920" in *United States OIA*.

should be increased."[22] In 1912, he argued that the "school also urgently needs a building for winter play house [sic]."[23] By 1915, sleeping porches and more space had been added to the boys' dormitory, but the same improvements had not been made for the girls' building; the superintendent urged this expansion.[24] The request to expand the girls' dormitory was repeated in 1917, and the appeal for a winter playhouse was reiterated in 1916 and 1919.[25]

While the dormitories clearly lacked space and needed modernization, in the form of sleeping porches, local administrators decided the other buildings in the complex were also too small. The hospital, in particular, needed to be enlarged, in part because the OIA medical service had been absorbed into the educational department. The school physician, as a result of this departmental consolidation, served the needs of not only the 227 children at the school but also the needs of the children's extended families on the LCO.[26] In the 1910 report, the superintendent stated only that the hospital "should be enlarged."[27] In 1912, he wrote that "more hospital room will enable us to accommodate

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[22] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 5.

[23] "Narrative Reports: Hayward Training School for year ending June 30, 1912 - Health" in *United States OIA.*

[24] "Narrative Reports: Hayward Training School for year ending June 30, 1915" in *United States OIA,* 5.

[25] "Narrative Reports: Hayward Training School for year ending June 30, 1917 – Material Plant" in *United States OIA,* 3.; "Narrative Reports: Hayward Training School for year ending June 30, 1916 - Health" in *United States OIA*.; "Narrative Reports: Hayward Training School for year ending June 30, 1919 - Health" in *United States OIA.*

[26] The official population of the Ojibwe living on LCO in 1903 was 1,145. Tribe members traveled between reservations, however, so the population on that reservation fluctuated. The official population of Ojibwe living on neighboring reservations at the same time: Red Cliff – 237; Bad River – 833; Lac du Flambeau – 755. Estimated total population of Ojibwe in the region: 5,090. *Statistics of Indian Tribes, Agencies, and Schools, 1903*, 41.

[27] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA.*

and care for a few of the most serious cases of sickness among the older Indians of the reservation," and he reiterated this request in 1913.[28] The superintendent added to the appeal in 1915, arguing that the hospital needed sleeping porches as well as an addition.[29] In 1917, the superintendent asserted that the "hospital here is … very small and poorly equipped. It is used more for agency patients than for [the] school. It should have space for maternity cases as well as other wards for both adult male and female separate from the wards for the school boys and girls."[30] By 1918, OIA reports began to regularly call for the agency to build a separate hospital on the LCO.[31]

As for the modern water and sewer system that was built into the school, the OIA officials who had designed the building clearly had ideas about what was appropriate – ideas that were different from ideas belonging to locals. School administrators continually complained that having the toilets, baths, and showers in the basement of the dormitories was unsanitary. In 1910, the superintendent argued that the bathrooms were a "source of trouble and labor and expense to keep in sanitary condition" and should be moved to "a structure apart from the dormitories."[32] An "annex" for bathroom facilities

[28] "Narrative Reports: Hayward Training School for year ending June 30, 1912 - Health" in *United States OIA*.; "Narrative Reports: Hayward Training School for year ending June 30, 1913 - Health" in *United States OIA*.

[29] "Narrative Reports: Hayward Training School for year ending June 30, 1915" in *United States OIA,* 5.

[30] "Narrative Reports: Hayward Training School for year ending June 30, 1917" in *United States OIA,* 3.

[31] "Narrative Reports: Hayward Training School for year ending June 30, 1918 – Health" in *United States OIA,* 5-6. "It is believed that a physician should be stationed at Reserve and that he should be equipped with quarters, a small hospital, and conveyance…"

[32] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 12.

was added to the boys' dormitory in 1914, but the improvement to the girls' dormitory was not made for many years.[33]

An issue that caused more consternation for Haywardites was the sewer system. The "6-inch sewer pipe" that connected to both dormitories as well as to the schoolhouse and the mess hall drained, by deliberate design, "into a small stream about 60 rods from the buildings."[34] Even in 1910, the superintendent thought this system was "perfect." He maintained, "We have a fine sewer system, which empties into a running stream. No cess pools, septic tanks or other undesirable features are necessary."[35] The sewage system, for that administrator and the school's designers, was apparently perfect when the sewage was out of sight, out of mind, and out of the range of smell. Haywardites, however, noticed a problem with that system only a short time after the school was completed. In 1904, the editor of the *Republican* noted that the town's drinking water was coming from a pond that was fed by that running stream. He argued,

> It is entirely out of the question to ask the people of this town to continue drinking the water as it comes from the pond now. There is an accumulation of slime on the bottom which is well calculated to breed almost anything. There is also a constant addition to this from many sources. … The sewage from the Indian school flows into the pond only a short distance above the intake and it cannot be said that the impurities have been taken out of it in the short distance the water travels.[36]

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[33] "Narrative Reports: Hayward Training School for year ending June 30, 1915" in *United States OIA,* 5.; "Narrative Reports: Hayward Training School for year ending June 30, 1917 – Material Plant" in *United States OIA,* 3.

[34] *Statistics of Indian Tribes, Agencies, and Schools, 1903*, 44.

[35] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA.*

[36] *HR,* 5 May 1904.

It was fifteen years before school officials agreed. In 1919, the superintendent wrote that the school had a "good clean supply of water" but that the facility needed a "septic tank to care for the sewage."[37] This new sewage system was finally installed in 1920, after the contamination of Hayward's water supply captured the attention of the SBOH. In January of that year, the *SCR* printed the results of a SBOH investigation. Although no Haywardite had died as a result of the contaminated water supply, about 300 people had recently fallen ill with symptoms, lasting from two days to three weeks, which included "severe abdominal cramps, vomiting, diarrhea, moderate fever and profound prostration."[38] Formal SBOH investigations of the situation in March and June 1920 led the Board to recommend that Hayward develop a completely new water supply and that the OIA school begin treating its waste.[39]

Overall, the Hayward Indian School's facilities looked fine on paper, but in practice, they were much less than adequate. The buildings within the school complex were overcrowded, even after expansion. The dual purpose of the medical facilities only exacerbated the building inadequacies. And, the plumbing was inconvenient for the students and dangerous for the surrounding community. Local school administrators were unconcerned, for many years, about the school's environmental effect on the health

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[37] "Narrative Reports: Hayward Training School for year ending June 30, 1919 – Health" in *United States OIA*.

[38] "The nation has gone dry but city water still has a kick," *SCR*, 22 January 1920. The SBOH recommended that illness sufferers abstain from all food or drink for at least 24 hours, and that physicians prescribe castor oil, which is a purgative. Both of these are questionable recommendations in cases of imminent dehydration.

[39] C.A. Harper M.D., *Twenty-Eighth Report of the State Board of Health of Wisconsin for the Term Ending June 30, 1920 with Report of the State Bureau of Vital Statistics for the Calendar Years of 1918 and 1919* (Madison, Wis.: Democrat Printing Co., State Printer, 1920), 132-4.

of the people who lived downstream, and OIA bureaucrats were indifferent regarding the complaints about facilities and plumbing that the local administrators actually voiced. The school complex had appeared to be more than satisfactory when it was in the planning stage; it was inconceivable that the complex would so rapidly become obsolete.

The school's medical service also had appeared to be satisfactory on paper but was wholly dependent on changeable local conditions. The school was to have a resident physician and nurse, and the school complex included a hospital. The hospital, however, was the old isolation hospital that had been part of the county's poor farm before the school was constructed; as such, it was hardly a modern facility. As for the physician and nurse, the quality of the care depended on the personnel, and it was often difficult to find people who were willing or able to work in the OIA boarding school system for extended periods. In 1910, the local superintendent reported that there were "no obstacles to the work of the physician and nurse" at the school but that "there have been so many changes in the position" of physician that not much had been achieved. The school had experienced a measles epidemic that June, in which 97 of the children had fallen ill.[40] Only two of these children had died in the epidemic. In April, it was discovered that two students had "incipient tuberculosis," and those children were immediately "separated from the other children, and placed in a tent where they were treated by the most modern methods," including a "diet of milk, cream and eggs."[41] The physician who worked at the school in 1912 made sure that all of his students were vaccinated and showed "great care in examining pupils who [applied] for enrollment," turning away those who were

[40] Out of the average attendance of 227 students, this represents a nearly 43% morbidity rate.

[41] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 9.

infected with either trachoma or tuberculosis.[42] In years like these, the children were adequately cared for; a potentially deadly epidemic was mitigated, hidden illnesses were identified and treated, and infections were prevented.

This was not always the case. Even the school superintendent noted in his 1912 report that the physician's work was much more thorough than it had been in years past, both in the school and on the reservation.[43] And, although 1912 was better than some earlier years, this was no guarantee that the medical service would continue to improve in the future. After all, the Secretary of the Interior acknowledged that year that the OIA-sponsored medical service was incompetent, as "several surveys of health and sanitary conditions … in schools and on reservations … disclosed an alarming prevalence of tuberculosis and trachoma."[44] President Taft sent this information to Congress with a request for over $250,000 in emergency funding for "medical relief" to ease the situation on reservations throughout the United States. He reasoned that

> As guardians of the welfare of the Indians, it is our immediate duty to give the race a fair chance for an unmaimed birth, healthy childhood, and a physically efficient maturity. … Prior to [1900] little attention had been given to the hygiene and health of the Indians. In some reservations, equal in area to a State, there were not more than two physicians, frequently only one. In 1909 tens of thousands of Indians were substantially without any chance to reach a doctor. [45]

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[42] "Narrative Reports: Hayward Training School for year ending June 30, 1912 - Health" in *United States OIA*. Trachoma is an eye infection that is particularly nasty; the infection produces granular pus that, if left untreated, causes blindness. In the first decades of the 20th century, trachoma was associated with the Native American population and with immigrants. Migrants who were found to be infected with trachoma were rejected and returned to their country of origin.

[43] "Narrative Reports: Hayward Training School for year ending June 30, 1912 – Health" in *United States OIA*.

[44] Tyler, *A History of Indian Policy*, 107.

[45] "Congressional Record," (August 10, 1912), 10, 643-4.

Even in 1912 dollars, this was a meager appropriation, but Congress did not match the request.[46]

The result of this reinvigorated national attention on Indian health, for the LCO children at Hayward Indian School was slight. In 1913, a Dr. Ferdinand Shoemaker, from Washington D.C., and his assistant visited the LCO, where they "gave illustrated lectures on tuberculosis and other diseases generally prevalent among Indians," after which they visited the school for a general – and cursory – inspection.[47] In late 1914, another physician visited the school and reservation; this doctor was the "superintendent of the eye disease department of the government schools" who was on his "annual tour of inspection."[48]

Beyond the random but exciting tours of inspection and illustrated lectures, it was business as usual. In 1913, the children experienced another measles epidemic, and a few of the pupils were found to have been infected with trachoma.[49] In early 1914, the doctor who had been working at the school for a few months "became insane," and his successor only stayed on the job for a couple of months.[50] Over the course of that year, the school employed three different doctors; it employed three more at various times the next year. In 1915, the superintendent complained

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[46] The congressional budget that year was approximately $690 million.

[47] *HR*, 23 October 1913.

[48] *HR*, 17 September 1914.

[49] "Narrative Reports: Hayward Training School for year ending June 30, 1913 – Health" in *United States OIA*.

[50] "Narrative Reports: Hayward Training School for year ending June 30, 1914 – Supplement" in *United States OIA*.

> Men who come to remain three to six months can do very little in health matters. Facilities for the care and treatment of chronic, cases, invalids, emergency cases, confinements, etc. are entirely lacking. The funds now expended for support of the school and Agency could all be applied the health improvement and sanitation with profit. As it is we have very little. A physicians salary, at $1000.00 and about $200.00 worth of drugs and medical supplies. We have no hospital, no food for sick, no nurse, in fact nothing but a physician and little medicine. This man must drive over miles of the worst kind of roads, in all kinds of weather, and in winter the hardship is unbearable. This accounts for so many changes, along with the salary, which is but a pittance for the work required.[51]

By 1917, the school no longer had a resident physician, as the position was eliminated the previous year. Instead, a contract was signed with one of Hayward's already overworked physicians, giving him $400 and mileage in return for a guarantee that he would visit when needed.[52]

For immediate and minor medical needs, the school now employed a resident nurse for a salary of $720 per year. This situation was still less than satisfactory. An OIA official noted during his inspection of the school in September 1918, that the "drug supply" that was to be for student use was

> being kept in a number of … places, including the attic of the hospital, which is accessible only by means of a ladder through a small trap door, a place where a lady nurse will not venture. No one seems to know what is there. Much of it is stored away in cases that have not been opened, and it would be impossible to check it through until it is removed to some more convenient place.

In fact, the inspector noted that there would be no nurse venturing into the attic soon, as "the position of nurse at the school at the present time is vacant." Many of the students at

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[51] "Narrative Reports: Hayward Training School for year ending June 30, 1915 – Health" in *United States OIA*.

[52] "Narrative Reports: Hayward Training School for year ending June 30, 1917" in *United States OIA*; C.M. Knight, Inspector, "Report on the Lac Courte Oreilles Reservation and the Hayward Indian Training School," (September 24, 1918), 1-3, "Statistical Reports" in *United States OIA*.

the school needed constant medical care for trachoma, and in the absence of a nurse, the duty of treating the children's eyes fell to one of the teachers. This teacher, unfortunately, had bad eyesight herself and was "particularly afraid of trachoma." Both circumstances made her an especially poor choice for a fill-in nurse.[53] A nurse had been found and employed by 1920, but the physician's work was still being contracted out from Hayward. The nurse, moreover, was being paid for treating 275 children, but school enrollment was 296. [54]

Given the difficulty of the job, it is no wonder why the physicians and nurses did not remain at the Hayward school longer. The pay was low, the work was hard, and the job carried little prestige. A job as an "Indian Doctor" was one that a physician took only to fill in a gap of employment. Real money and prestige were to be found in thriving white communities, not among a socially and economically marginalized population that typically lived far away from important urban areas. Physicians who remained at reservations developed reputations akin to those of the government farmers (see Chapter 3). That is, they were suspected of remaining there because they were corrupt or inept.

Furthermore, when physicians arrived at the reservations, even if they came with noble intentions, they found that they faced a nearly impossible situation. The Native Americans who were supposed to be receiving the healthcare viewed the physicians with great distrust, especially with the long history that the reservations had with corrupt government farmers. Additionally, the physicians were generally encountering a culture and notions of healthcare that were radically different from their own. When the School

[53] *Ibid*., 12-13

[54] "Statistical Reports: 1920" in *United States OIA*.

Sisters of St. Francis began their mission school on the LCO, their healthcare work was based on teas, bathing, and prayers, which integrated nicely with the Midewiwin system. A "modern" physician of the early 1900s treated his patients with pharmaceuticals, pills, and scalpels; he undoubtedly faced serious cultural resistance. Even after OIA officials began to visit reservations with entertaining slideshows and lectures about trachoma and tuberculosis, the physicians had difficulties fitting in. In 1910, the Hayward School superintendent maintained that "On the reservation the usual tribal customs, medicine men etc., have their influence against the treatment of the sick by the physician, and against hygiene and sanitation."[55]

Perhaps if the school had been successful in teaching its students to be good American citizens, as it was intended to do, cultural barriers would have broken down, and the job of the physician would have been easier. However, the Hayward Indian School did not do a better job in educating its students than it did in caring for its students' health. In 1910, the superintendent admitted that he had "refused to grant certificates of graduation" to students who were likely to resume the Ojibwe way life once they returned to the reservation, as that would "bring dishonor to the school."[56] Students who attended the school, moreover, were taught agriculture and homemaking instead of reading, writing, and arithmetic.[57] An inspector who visited the school in 1917 noted that the school's disciplinarian was doing a good job "training [the students] in military-marching and formations." However, during meal times, the students were

[55] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 10.

[56] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 7-8.

[57] "Narrative Reports: Hayward Training School for year ending June 30, 1910" in *United States OIA,* 3.

eating with their fingers rather than with utensils and were lying on the tables while they were eating. And, on Sunday afternoons when the children should have been "taught Bible stories, moral precepts, and belief in a supreme Being [sic]," the superintendent was telling "Bible history stories emphasizing the sensuous and bad acts of the characters rather than the inspirational parts."[58]

The value of the students' education in homemaking and home health care was dubious. Students who helped in the school kitchen were not being taught to keep it in a sanitary condition; it only contained "one small garbage can," and the garbage that had been removed from the kitchen was being kept in boxes just outside the door. The inspector who visited in 1917 maintained that the situation would breed flies in the warm weather. The cellar under the kitchen was also far from clean. The inspector noted that "the odor issuing from it could be detected a rod away from the outside entrance," but the odor would be taken care of if only the cellar was cleaned and whitewashed. Finally, the students were not brushing their teeth, and when they did, they allowed the wet brushes to mingle with each other, thus facilitating the spread of disease.[59] And as late as 1918, the few improvements that the physical plant had been afforded were not being fully used; the sleeping porches on the boys' dormitory, for example, remained unused, despite the students' desire to sleep in the open air.[60] Nationally, Native Americans had the reputation of being especially susceptible to tuberculosis, so the neglect of well-known

[58] W.W. Coon, Ass't Supervisor of Ind. Schools, "Report on Supervision of the Hayward Schools" (May 21-31, 1917), 9-10, "Statistical Reports" in *United States OIA*.

[59] *Ibid*., "Health and Sanitation" p. 1-2

[60] C.M. Knight, Inspector, "Report on the Lac Courte Oreilles Reservation and the Hayward Indian Training School – Health" (September 24, 1918), 5, "Statistical Reports" in *United States OIA*.

sanitary precautions and accepted preventatives within this particular school can only indicate that the local administrators did not care to make the effort.

It becomes increasingly evident in the historical record that the children attending the Hayward Indian School had teachers who were more bureaucrat than educator, and they had caregivers who were more civil servant than nurse. The school's experience during the Spanish Influenza epidemic of 1918 demonstrated the gravity of the situation: the schoolchildren suffered much higher morbidity and mortality rates than the Haywardites who lived less than two miles away. Moreover, the children suffered these higher rates even though they were supposed to have direct and immediate access to a nurse and a matron, to teachers who were supposed to be teaching "right living," and to a hospital that had an attic full of pharmaceuticals.

This epidemic presented an admittedly unique situation for the local superintendent and his staff. There was no cure or preventative for the disease, which seemed to strike randomly and to favor the healthiest citizens within the population. Spanish Influenza made its first American appearance in the spring of 1918, when a mild flu appeared at Fort Riley, Kansas. Victims of this flu typically complained of sore throats, fevers, and aching backs for about three days. Some of the sufferers developed pneumonia, and a few of those died. This was only to be expected in an era in which pneumonia often led to death. This flu, even in its early appearance, was different; it spread more rapidly than other contagions had done, and mortality rates were slightly higher than expected.[61]

[61] For more on the global pandemic, see: Richard Collier, *The Plague of the Spanish Lady: The Influenza Pandemic of 1918-1919* (New York: Atheneum, 1974); Alfred W. Crosby, Jr., *America's Forgotten*

When American soldiers traveled to Europe to fight in World War I, they carried this flu virus. In the midst of war and the integration of large populations of young men from areas throughout the world, the virus mutated into a form that was truly dangerous. Victims of this mutated virus fell perilously ill, sometimes with little or no warning. If the sufferer survived the rapid dehydration that the flu caused, he or she might develop a form of pneumonia that was especially virulent. Mortality rates soared, and the most spectacular stories began to appear in the newspapers – stories of young, tragic victims of the disease who seemed to be healthy when they simply dropped dead in the streets. As Spain was a noncombatant and was open to the press, many of the earliest of those spectacular stories originated there. This new flu soon became known as the Spanish Influenza. Despite the name, the disease was a global pandemic. Historians estimate that at least twenty million people died around the world during 1918 and 1919.

Wisconsin's first recorded encounters with the Spanish Influenza occurred in late September 1918, when cases began to appear in Milwaukee. The city's health department strictly cautioned local physicians to report and track the progress of the disease. Within two weeks, there were reports that the disease had progressed all the way to the University of Wisconsin in Madison. The SBOH, at this point, took action. It advised citizens to avoid public gathering places and to institute self-quarantines; citizens were warned against spitting, kissing, and "public coughing." These admonitions, of

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Pandemic; and Gina Kolata, *Flu: The Story of the Great Influenza Pandemic of 1918 and the Search for the Virus That Caused It* (New York: Farrar, Straus and Giroux, 1999).

course, were insufficient in the face of such a deadly virus. On October 10, 1918, the SBOH issued an order that closed all public institutions, including schools.[62]

There may have been some confusion at the Hayward Indian School regarding this order. The school was managed by the OIA, a federal agency, and the children that lived at the school were also part of a federally managed population. The school itself, however, was located off the federal reservation and on Sawyer County land. Perhaps if the Hayward schools had closed on October 10, the administrator at the Indian School might have considered that action. Perpetually resistant to state interference, however, county authorities did not issue a local order for two months, by which time the disease had made its presence strongly felt.[63] As most of the children at the school had come from local Ojibwe tribes, it would not have been out of the question to send them all home and to close the school until the epidemic had passed. The Hayward Indian School, however, remained open, although students did not attend class. The confusion regarding jurisdiction might have contributed to this decision; the faith that the school superintendent, his staff, and the OIA bureaucrats had in the modern facilities and their perception that the school's healthcare was well in hand also likely contributed to the decision.

Whatever the reasoning behind the school's continued operations, it was clear by the first week of November that Sawyer County was suffering. On November 7, Hayward's mayor issued an order that required masks to be worn by all citizens from homes where there was flu. Also on that day, one of Hayward's doctors reported that all

[62] Burg, "Wisconsin and the Great Spanish Flu Epidemic of 1918," 43-5.

[63] *SCR*, 12 December 1918.

cases of the flu on the LCO were "improving very nicely" and that the disease would soon be wiped out, as long as no new cases developed.[64] Of course, that was the problem; there was no way to prevent new cases from developing. Even one of Hayward's physicians, Dr. Larsen, was struck by the disease the following week and so was unable to help stop the epidemic's spread.[65] By the end of the year, the official number of Sawyer County cases reported to the SBOH was 99, with 25 deaths – a death rate of 308 per 100,000.[66]

With the general lack of sanitary practices in place at the Hayward Indian School, it is no surprise that the flu spread quickly among the student population. The kitchen remained unclean, even after the inspector's 1917 report, the toilet facilities remained in the basement, and the students' toothbrushes still hung next to each other. In addition, immediately before the epidemic struck, there was no nurse on staff, and the school's pharmaceutical supplies remained in the attic. During the last two weeks of November, the influenza virus was contracted by the majority of residents at the school. Hayward's newspaper reported that 180 of the 225 official students had the flu, and "all but four employees" also were stricken. At one point, 183 people were in bed with the disease, and they were being tended to by Hayward's two resident doctors along with a physician from a neighboring community. For the first week of the crisis, two registered and eleven practical nurses from the surrounding areas had come to the school to assist, but after a week, four of the nurses had returned to their own communities, which also

[64] *SCR*, 7 November 1918.

[65] *SCR*, 14 November 1918.

[66] 28th *SBOHR*, p 53. See: 1918 death rates per 100,000 in Wisconsin

needed their help. Also assisting the healthcare workers at the school were Father Gordon, who visited briefly during the first week of the epidemic, and another priest, Father Habraken, who "was called to the school … to administer the last Rites in the Faith to a number of the pupils whose lives were despaired of in consequence of pneumonia." Seven of the students between the ages of 8 and 18 died from the disease.[67]

The fact that all of these children were confined in overcrowded facilities certainly contributed to the high morbidity and mortality rates in late 1918. The dormitories had never been adequate for the school's needs. The fact that the Spanish Influenza virus took an especially heavy toll on those who were young and presumably healthy also contributed to the sad situation at the school. Perhaps more important than these two material conditions, however, was the over confidence in the promises of modernity that had been bred into the culture of the school administration and the bureaucracy that prevented the administrators' ability to be flexible in the face of rapidly changing conditions. The educational zeal that prompted OIA bureaucrats and progressives into creating institutions that would teach American citizenship and right living had, instead, only reinforced the lessons that the Native American communities had learned from their contacts with the OIA for many years. First, the children learned to devalue traditional community-based healthcare; the children were denied that healthcare when they were not sent to their reservation homes at the first sign that the epidemic was coming. Second, the children learned that no matter how optimistic the government program was, the implementation of the program depended on the presence

[67] *SCR*, 28 November 1918. The school's attendance figures remained close to 225 until 1920, when the official enrollment jumped to 294. Even if the school's population in 1918 had been 294, the death rate per 100,000 would have still been an astronomical 2,380.9.

of individuals who shared that optimism. The people who were committed to providing the children's healthcare were members of other communities first; as such, they treated the children as second-class citizens, as members of no community. As potential American citizens, the children had been promised good health; as Native American children, they had no such right.

Fig. 7.1
Postmark is 12/3/1911.[68]

[68] "Indian Trainings School, Hayward Wisc.," (Bloom Bros., Importers: Minneapolis) n.d. Postcard from author's collection.

Fig. 7.2[69]

[69] "Government Indian Training School, Hayward, Wis." (Kropp Co.: Milwaukee) n.d. Postcard from author's collection.

CONCLUSION:
A SISTER'S SCHOOL
AND AMERICAN HEALTHCARE

In 1925, Sister Sirilla LaRush returned to her family's home on the LCO in order to visit her sick father, and she took this opportunity to visit the mission school that had deeply touched her life when she was young. When she was born, she had been named after one of the School Sisters of St. Francis, and when she was old enough, she had attended the mission school. Because she was Ojibwe, she went to the Hayward Indian School when the school sisters left the LCO. However, she did not like the OIA school, and she hid in her father's sled in order to run away and return home. In 1904 when the little girl received her first communion from Father Agatho (see Chapter 3), she decided that she would take vows and become one of the school sisters when she grew up. Twenty-one years after her first communion, Sister Sirilla had taken her vows, received her training at the motherhouse in Milwaukee, and had a teaching job in Nebraska.[1]

What Sr. Sirilla found when she returned to the LCO was certainly different from what she remembered of growing up at the mission school. The mission church, in which Fathers Agatho and Gordon had preached, was struck by lightning in 1918 and had burned to the ground; a new church had only been partially built.[2] The community had been further disrupted by the construction of a dam, which had created the Chippewa

[1] Stiefermann, *Stanislaus … With Feet in the World*, 162; and "Fabiola (Sister Sirilla) LaRush," St. Joseph Convent Archives. Sister Sirilla's given name was Fabiola; Sister Fabiola was stationed at the mission school from 1890 to either 1893 or 1894 (see Table 3). In 1925, then, she would have been in her early 30s.

[2] "Fabiola (Sister Sirilla) LaRush," 16-7.

Flowage and which supplied electrical power to the region. One of the larger LCO settlements, including an old cemetery, had been flooded by the dam, and the Ojibwe from that settlement had to be relocated to another area of the reservation.[3] The priest who had charge over the LCO did not recognize Sister Sirilla, nor did he "trust" her or give her supper until her baptismal record was located. When she finally arrived at the old mission, the sister found that the children who lived there were "unruly," the sanctuary and sacristy were filthy, and the situation as a whole was a "mess [that] just could not be described [sic]." Sister Sirilla "cried [herself] out to experience such an abandonment and neglect in that Church."[4]

With approval from the Mother Alfons (see Chapter 3), Sister Sirilla resigned her position in Nebraska, rehabilitated the mission church, reestablished the mission school, and opened a "small clinic" (see Figs. 8.1-8.2). She served there for the next twenty-nine years, despite occasional difficulties with staffing, extreme weather conditions, and "the bugs and rodents which infested the sisters' cabin." However, the children were often uninterested in what the sisters had to teach, and the community was beset by poverty and alcoholism. One sister who served at the school wrote that the "children come mostly from homes in which sanitary neglect and utter poverty prevail." It is not surprising, given this poverty and sanitary neglect, that the LCO Ojibwe suffered "ill health and

[3] The priest who was in charge of that particular community "had some of the graves … removed to main land," but it is clear that some graves remained. *Ibid*., 19.

[4] *Ibid*., 22-3.

malnutrition." A "small clinic" and an eight-grade mission school would do little to change these underlying conditions.[5]

During the school sisters' absence from the LCO, the Ojibwe had learned that they were supposed to receive health care through the OIA and other government agencies. Ojibwe living on other Wisconsin reservations were doing just that; the WATA, for example, conducted free tuberculosis screenings for Red Cliff Ojibwe near Bayfield and Bad River Ojibwe at the St. Mary's school in Odanah in the early 1930s, and the OIA employed a resident physician at the Lac du Flambeau reservation beginning in 1932.[6] In the absence of a clinic or an OIA physician, the Ojibwe continued their Midewiwin practices, but they did so with the knowledge that "better" health care should be available.

The school sisters, with their small clinic on the LCO, continued their health care practices that they learned at the motherhouse in Milwaukee. Those practices, however, had also changed since Mother Alexia had first brought the Kneipp method to the order in the early 1890s. After the state of Wisconsin had interfered with the sanitarium's training and nurse certification in 1924, the sisters' training had become formalized and state-approved.[7] The sisters operated their small clinic and undoubtedly continued to provide comfort to the community, just as they had done in the 1890s. But, they did so

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[5] Stiefermann, *Stanislaus … With Feet in the World*, 162-3.

[6] "The Odanah Indian Clinic," "Another Indian Clinic at Odanah," and "Statement by J.D. Mitchell, M.D. on Health Conditions at Lac du Flambeau Reservation" in *WPA Indian Research Project Collection, 1936-1940*, ed. Macaria Murphy (Milwaukee: Marquette University Department of Special Collections and University Archives, 1983).

[7] Euper, 43. See Chapter 3, footnote 87.

with the knowledge that "better" – and government directed – health care was available elsewhere.

In the course of researching and writing this dissertation, I spent long hours discussing what I found with my aunt from northern Wisconsin (see Introduction). In return, she also spent long hours relating her personal experiences as a public health nurse in the 1950s through the 1980s. She had studied nursing at Marquette University under the tutelage of Franciscan sisters, graduated in 1949 with a bachelor's of science, and then earned her certification in public health nursing in 1953.[8] In her more than twenty years of experience as a public health nurse in southeastern Wisconsin, she had encountered many of the issues that I was researching. Because her education and public health experience happened long after the time period covered by my research, her experiences often paralleled my research in a distorted way.

An examination of these distortions was quite illuminating. For example, while the enforcement of quarantines in Hayward – quarantines that were initiated by the city's health officer – was problematic, my aunt had the ability to investigate illnesses in families who lived in her region of Milwaukee, diagnose those illnesses as contagious, and quarantine those families. This was an extraordinary amount of power to be held by a young woman in the early 1950s, especially when compared to the failures of quarantines initiated by Hayward's respected Dr. Trowbridge. And when she directed vaccination clinics at which children received protection from polio, measles, and diphtheria, she encountered little opposition, even though she was working in some of the

[8] These sisters were from the Daughters of the Sacred Hearts of Jesus and Mary, in Wheaton, IL. This order, like Mother Alexia's School Sisters of St. Francis, was established by refugees of the *Kulturkampf*.

same neighborhoods in Milwaukee that had been central to the anti-vaccination movement in the 1890s (see Chapter 5).

These changes in the reception of public health efforts reflect more than just an acknowledgement of the increasing effectiveness of scientific research and developments in the practice of medicine. The discovery of effective preventative vaccines for polio, measles, and diphtheria certainly underscored popular acceptance of public health efforts. However, smallpox vaccinations had also been effective in the 1890s, yet they were poorly received by many citizens who were ultimately wary of government interference in their daily lives. The surprising acceptance of my aunt's quarantines reveals that something bigger than medical discoveries had changed between the late 1800s and the 1950s.

What those medical discoveries had supported was a growing acceptance of government interference in American's daily lives. The two conditions went hand-in-hand – both dependent on each other's existence. Hayward's physicians and health officers of the late 1800s, for example, often ignored state orders regarding the reporting of birth, death, and disease statistics because they did not see the value in doing so. By 1919, this value was evident; statistics showed that there was a clear problem in the community related to water tainted with sewage, and the state was able to recommend a practical and effective solution. Information regarding the discovery of the tuberculosis bacillus in 1882 and developments in the medical treatment of TB were marketed to Haywardites and LCO Ojibwe through efforts of the NATA and the WATA, both organizations that received government support and funding. And government certification regarding the educational background and abilities of physicians, in the form

of licensing, would come to represent beneficial healthcare – healthcare that resulted in clearly positive outcomes.

With acceptance of this authority came a change in the definition of health and disease. When diseases like tuberculosis and polio (see Chapter 3) could be identified by science and treated with government support, the appearance of the disease became an emergency situation, demanding immediate medical – and sometimes governmental – intervention. The absence of disease became a goal that seemed accessible, especially as scientific research progressed and governmental interference in daily lives intensified. And the progressive promise that cooperation between science, education, and the government would lead to better lives caused citizens to believe that disease could be conquered, if only scientific, educational, and governmental recommendations were carefully followed. In short, a disease like Albert Sabean's tuberculosis (see Introduction) was one that would be viewed as an abnormality instead of as a normal, albeit unwanted, element of life.

By 1920, the growing expectation was that government and medicine had the answer for whatever ailed Haywardites and the LCO Ojibwe. When this faith was put to the test at the Hayward Indian School, however, it became evident that the gospel of modern healthcare was less than satisfactory. Effective medical care relies upon practitioners who are able to provide and interested in providing that medical care. It does not depend on the ability of bureaucrats and politicians to design buildings, argue about appropriations, and write statistical or narrative reports. Certainly, the buildings must be built, the money needs to be provided, and the information needs to be gathered in order for the practitioner to have the ability to effectively practice medicine. However,

none of these activities can create interest. Bureaucracy, in fact, tends to eliminate interest.

Sister Sirilla understood that what she encountered at the LCO in 1925 was much different from what she remembered of that community in the late 1800s. The mission church and school had changed, the priest was a stranger, and much of the community itself had been relocated. More had changed, however, than she consciously understood. The LCO Ojibwe, like their neighbors in Hayward, had accepted the idea that there was no health care without government direction, and they recognized the inability of government to successfully provide that care. Certainly by early 21st century standards, Haywardites and the LCO Ojibwe were generally healthier in the early 1920s than they had been in the 1880s. They were the beneficiaries of scientific discoveries and government-directed efforts, at least in the fight against tuberculosis, trachoma, and diseases carried by raw sewage. And, they would benefit from discoveries over the next few decades – discoveries that would lead, for example, to effective treatments for syphilis and preventatives for measles and diphtheria. The failures of progressive promises, however, and a heightened awareness of the intensity of health and disease ultimately led to the perception that "there was no health care up here back then" and "the health care system we have here now is terrible.

Fig. 8.1
The school sisters' building, long after the arrival of Sister Sirilla.[9]

[9] "St. Francis Solanus School on the Reserve, Lac Court Oreilles, Stone Lake, Wis." n.d. Postcard from author's collection.

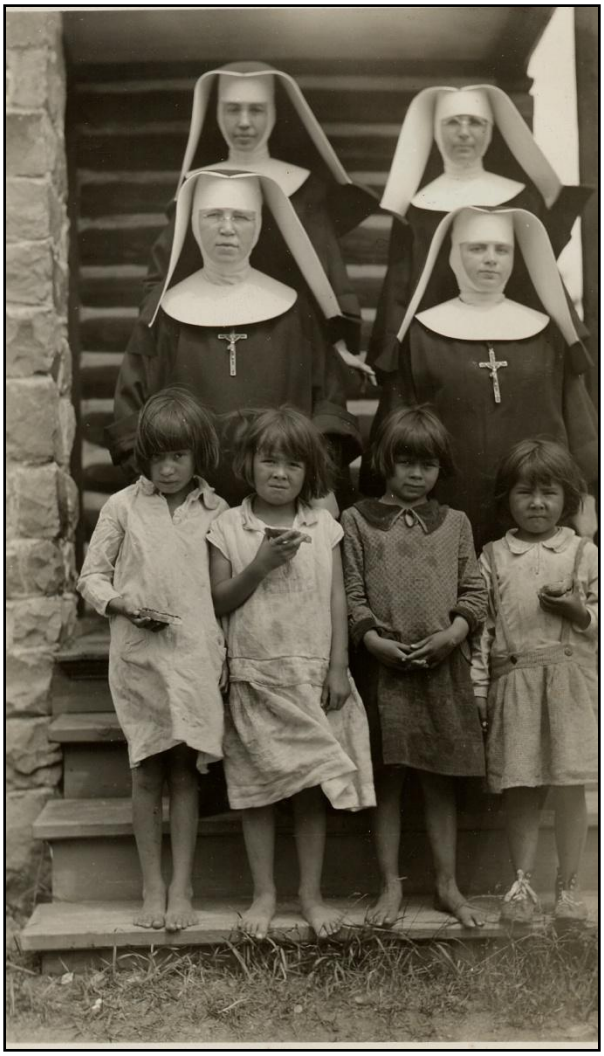

Fig. 8.2
School Sisters of St. Francis and some of their pupils on the Lac Courte Oreilles reservation. Sister Sirilla is either the top or bottom left.[10]

[10] "Catholic Nuns with Ojibwa Gils, 1932" Bureau of Catholic Indian Missions, 09-1 57-05 Courtesy of Department of Special Collections and University Archives, Marquette University Libraries.

Table 1

Distances in miles from Hayward to various destinations via the Chicago, St. Paul, Minneapolis & Omaha Railroad:[1]

Spooner	26
Rice Lake	50
Ashland	58
Chetek	65
Bayfield	75
Chippewa Falls	96
Eau Claire	106
St. Paul, MN	125

Table 2

1918 death rates per 100,000 in Wisconsin[2]

All Causes	1370.1
Meningitis	10.2
Diphtheria	10.7
Measles	6.1
Poliomyelitis	3.5
Scarlet Fever	7.8
Smallpox	.5
Tuberculosis (all forms)	95.0
Typhoid Fever	4.0
Whooping Cough	7.5
Influenza	279.3

[1] H.M. Pearce, "Table of Distances," (St. Paul, MN: Chicago, St. Paul, Minneapolis & Omaha Ry., 1901), WHS.

[2] 28th *SBOHR*, Table No. 4 – "Comparison of death rates per 100,000 population from all causes and from certain communicable diseases in Wisconsin in 1918 and 1919 with those of the United States registration area in 1918," 53.

Table 3

Sisters serving at the St. Francis Solanus Mission between 1886 and 1919[3]

	School Sisters of St. Francis				
1886	Concepta	Aloysia	Paschalis	Rosalia	Blasia
1887	Concepta	Aloysia			
1888	Concepta	Aloysia			
1889	Concepta	Aloysia	Angelina		
1890	Fabiola	Frances			
1891	Fabiola	Frances			
1892	Fabiola	Frances			
1893	Fabiola	Frances			
1894	?	?			
1895	Hugolina	Euphrasia	Anastasia	Ivo	
1896	Hugolina	Euphrasia	Anastasia	Ivo	
1897	Hugolina	Euphrasia	Florentine		
1898	Hugolina	Euphrasia	Florentine	Emmirica	
1899	Hugolina	Euphrasia	Petronella	Florentine	Josaphat
1900	Hugolina	Euphrasia	Petronella	Florentine	
1901	Arsenia	Euphrasia	Eligia		
1902	Arsenia	Euphrasia	Nepomuca	Zaccaria	
1903					
1904	Arsenia	Ottona	Nepomuca	Adelgunda	
1905	Arsenia	Ottona	Nepomuca	Mauritia	
1906	Arsenia	Ottona	Nepomuca	Petronella	Bonifasia
1907	Arsenia	Ottona	Nepomuca	Leonarda	
1908	Arsenia	Ottona	Nepomuca	Inviolata	

Sisters of St. Joseph

1909 – 1919

Mother Evangela Sheehan

John Berchmans Mullaly	St. Ann Bollam	Xavier Graney	Loretta Hart
Marie DeLourdes Hudson	Bernard Dooley	Joseph Foley	Agnes Reitz
Edna Joseph Haggerty	Augustine Bower	Miriam Merkel	Lucille Erwin
Angelita Linneman	Cecelia Rowland	Eugene Glass	Gertrude Falk

[3] Derived from: Sister M. Francis Borgia, OSF, *He Sent Two*; "Brief History of the Catholic Mission of Courtes Oreilles, Wis.," *BCIM General Correspondence*, ser. 1-1, reel 24; Sister Jo Ann Euper, OSF, *1st Century of Service*; Fowler, "Centennial."

Table 4

Ojibwe Medicines[4]

Plant name	Used for…
Red Maple	stomach trouble female disorders sore eyes
Sugar Maple	stomach trouble disguise the taste of bad medicine
Arum-leaved Arrow-head	fortifier stomach trouble - to prevent indigestion
Smooth Sumac	throat gargle diarrhea
Wild Sarsaparilla	blood purifier skin diseases rheumatism pregnancy tonic
Indian Spikenard	Boils
Wild Ginger	Indigestion
Speckled Alder	skin diseases tubercular eruptions
White Birch	women's medicine
Yellow Birch	female disorders
Hazelnut	female disorders Tuberculosis
Highbush Cranberry	injuries during pregnancy

[4] Derived from Peter Halfday, Florina Denomie, and Caroline Parker, "Chippewa Indian Remedies," in *WPA Indian Research Project Collection, 1936-1940*, ed. Macaria Murphy (Milwaukee: Marquette University Department of Special Collections and University Archives, 1983).

Common Burdock	coughs, colds, and pleursy Rheumatism
Joe Pye Weed	women's medicine newborn bathing shampoo hip medicine fortifier
Indian Cup Plant	spinal trouble lumbago rheumatism
Red-osier Dogwood	mouthwash sores
Prince's Pine	blood and nerve tonic
Wintergreen	rheumatism stomach trouble disguise the taste of bad medicine
Wild Geranium	men's tonic kidney troubles
Blue Flag	sore throat mouthwash pin- and tape-worms juice rubbed on shoes will repel snakes
Wild Mint	preventing colds checking fevers colic, cramps, stomach troubles hoarse throats infant baths
Sweet Fern	colic, diarrhea
Bloodroot	chest diseases lung hemorrhage, pneumonia heart disease tonic blood purifier

Balsam Fir	cathartic lung medicine colds
White Spruce	pin worms tuberculosis
White Pine	tuberculosis
White Cedar	fumigant, incense counteract bad medicine of witchcraft headaches rheumatism, rickets infantile paralysis
Hemlock	colic diarrhea disguise the taste of bad medicine healing cuts and wounds lumbago rheumatism loose bowels
Common Plantain	poison ivy insect stings wounds and sores burns
Maiden Hair Fern	post childbirth blood remedy
Gold-Thread	sore throat, cankerous mouth cuts and sores cough
Pin Cherry	cough, colds lung medicine worms tuberculosis eye infection
Choke Cherry	lung medicine female trouble

	sores mouthwash
Wild Rose	eyewash
High Bush Blackberry	diarrhea stomach disorders
Red Raspberry	diarrhea
Prickly Ash	colds, congestion, bronchitis heart stimulant
Balsam Poplar	cuts and sores
Shining Willow	sores and skin diseases
Wild Red Currant	women's medicine
Slippery Elm	female trouble
Culver's Root	blood tonic
New Jersey Tea	lung medicine
Prairie Smoke	women's medicine post childbirth remedy
Red Cedar	women's medicine
Horsemint	heart stimulant headwash
Ironwood	kidney medicine
Black Ash	earache
Marsh Five-finger	convulsions stomach cramps colds

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VITA

Kirstin Lawson grew up in southern Wisconsin, surrounded by family members who were nurses and by their reading materials. While most of her grade-school peers were reading comic books and watching poorly-made television shows, Kirstin was reading professional nursing magazines, like *Nursing*, and old copies of *American Heritage*. Thus, she grew to have an unusual affection for both history and medicine. An inborn aversion to seeing blood and to watching others suffer in pain convinced Kirstin that she should not choose medicine as a career. And, as books rarely cause any blood to flow, except in the case of paper cuts, she decided to write them instead.

Kirstin earned a B.A. from Texas A&M University, Corpus Christi in 1999, under the direction of Dr. Alan Lessoff. She earned her M.A. at the University of Missouri in 2001, under the direction of Dr. Mary Neth. And in the fall of 2008, she will be teaching History at Westminster College in Fulton, Missouri, where she will also be continuing her research into the development of health care systems within the Catholic orders.