

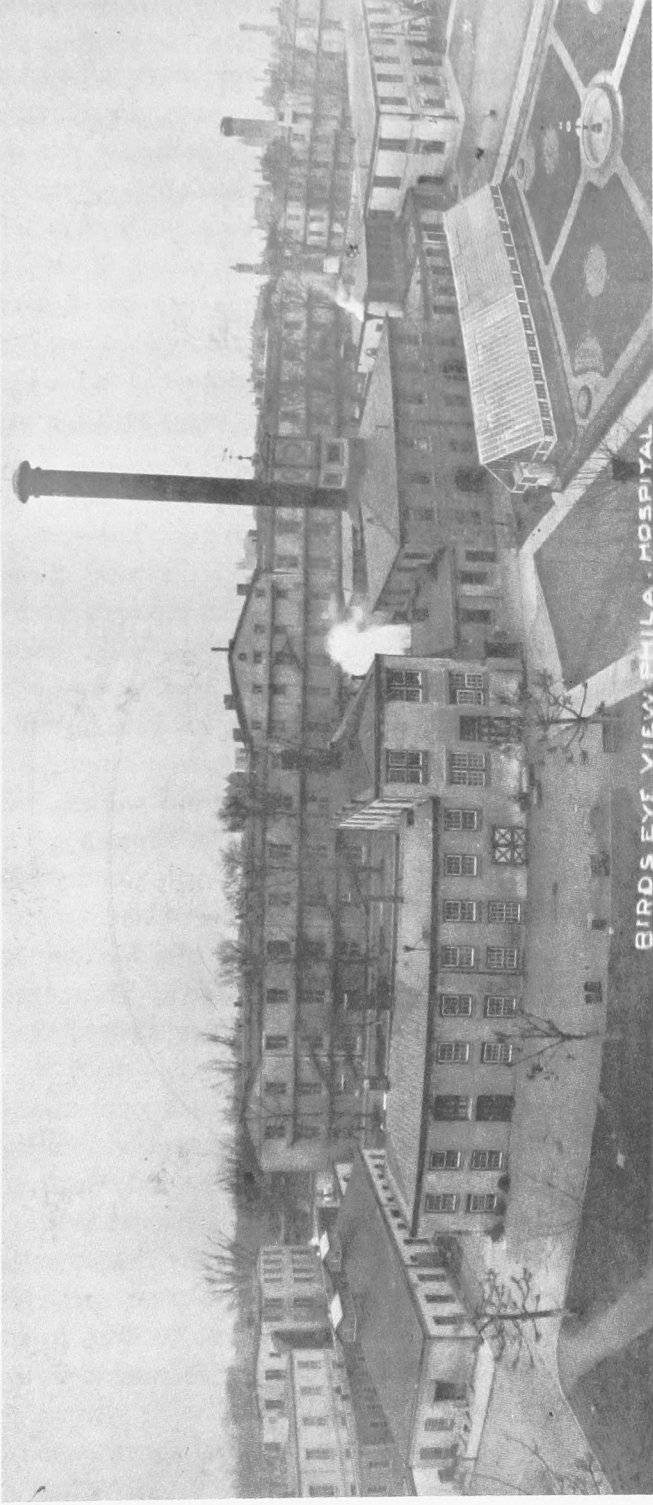
From Almshouse to Hospital: The Shaping of Philadelphia General Hospital

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IN 1932, THE PHILADELPHIA GENERAL HOSPITAL proudly celebrated its bicentennial. David Riesman, chairman of the hospital's medical board and a principal speaker on this occasion, was certain that despite the depression and its threat to traditional medical care patterns "in the coming realignment of all the forces making for better health the public hospital will occupy a central position, a position of far greater importance than in the past. The New Philadelphia General Hospital aided by a progressive staff and a liberal municipality will take its rightful place in the coming era" (Riesman, 1933).

This was no mere effusion of parochial loyalty. The Philadelphia General was not simply a very old institution; it could make a strong claim to being America's first hospital and by the 1930s had attained an international reputation for its clinical teaching and research. Nevertheless, its history after the Second World War—like that of many other municipal hospitals—grew increasingly bleak; and in 1976 Philadelphia announced plans to close its municipal hospital. It succumbed with surprisingly little public protest. To many observers, the hospital's demise seemed only a particularly dramatic but entirely



Birds Eye View of Philadelphia General Hospital

representative symptom of a more general decay in the quality of public medicine in America's older cities.

The story of Philadelphia General is, in some ways, a bit atypical; it was larger than most municipal hospitals, more prestigious clinically, founded earlier than almost all—but in others it was characteristic. Our older municipal hospitals all developed as welfare institutions, many like Philadelphia General or New York's Bellevue out of one aspect of a city's almshouse. The gradual differentiation of such municipal welfare mechanisms into a half-dozen successor functions and agencies was a complex and ambiguous process; the municipal hospital cannot be understood without a more general understanding of that elusive and in some ways still incomplete evolution.

By the first decades of the nineteenth century, every American city had established an almshouse; the larger the city, the greater the number of rootless and dependent who were its natural clients. "I visited the almshouse today," a young Bostonian reported from Philadelphia in 1806, "where I saw more collective misery than ever before met my eye" (Shattuck, 1806). The internal make-up of the almshouse inevitably reflected the diversity of misfortunes afflicting its clients. One set of wards housed the chronic unemployed (and often unemployable), another "old men" and "old women," others the sick, the delinquent, the minor dependent, the crippled and blind, the mentally incompetent. During the eighteenth century, in the larger cities such as New York or Philadelphia, special wards were assigned to the sick and physicians engaged to care for these unfortunates; by the 1820s, almshouse populations were in practice selected more by sickness than any single factor—other than dependence itself (Alexander, 1973; Wiberley, 1975).

Doctors, of course, were anxious to enlarge their opportunities to teach and learn—and thus eager to staff these institutions. In Boston, for example, such almshouse beds provided the only institutional medicine in the years before the Massachusetts General Hospital accepted its first patients in 1821; in Charleston, the almshouse served the same function until the 1850s, when the city's Roper Hospital opened its doors (Bowditch, 1872; Waring, 1967). Even in smaller communities such as Salem, Massachusetts, or Richmond, Virginia, aspiring physicians were happy to serve as almshouse visitors. At no time was public medicine not related to medical careers—and at no

time was it easily distinguishable from the more pervasive problem of dependency and the values associated with it.

In the following pages I have chosen to emphasize the history of Philadelphia's municipal hospital, partly because its records are uniquely complete, partly because it was important and influential; most importantly because its problems were representative. Each of our older cities constituted a somewhat different social environment and elaborated a similarly distinct history of policy decisions. Boston, New York, Baltimore, Philadelphia, and Chicago, for example, were all to arrive at somewhat different institutional solutions to their need for a municipal hospital; yet just as many of the older English workhouse hospitals are still identifiable in the National Health Service, none of America's older city hospitals could entirely erase the marks of their almshouse ancestry.

An Old Institution in a New World

As early as the first years of the nineteenth century, the sick wards in Philadelphia's almshouse were the city's most important hospital facility; this reality did not change throughout the century. As late as 1894, the Philadelphia General Hospital treated as many patients at one time as all the city's other flourishing hospitals put together.¹ In the first decade of the century, the almshouse averaged some 200 occupied "sick" beds, while the Pennsylvania Hospital cared for no more than 30 to 60 at any one time. In the years between 1804 and 1811, the almshouse admitted some 1300 to 2100 hospital patients each year—and its lay administrators were understandably resentful that their more socially elevated competitor continued to receive state aid, while the almshouse was ignored. Although its hospital function was somewhat obscured by other responsibilities, Philadelphia's almshouse was by the 1820s very largely a hospital. In 1821 the institution had fifteen wards for adult females; this had increased to eighteen by 1826. Three were for women well enough to work and two were for vagrants. The rest were all medical wards. There were nineteen wards

¹ Philadelphia General Hospital, *Annual Report for 1894* (1895), p. 70. Hereinafter cited as AR followed by the year covered in the report; the reports were always published in the following calendar year.



Sick Ward

for adult men in 1826—and of these, only three were for inmates well enough to work regularly (Clement, 1977; Williams, 1976).

The almshouse not only treated what were for the time enormous numbers of patients, but these patients were also drawn overwhelmingly from among those Philadelphians without roots in the community and from groups sharply divergent from the Quakers and Episcopalians who dominated so much of the city's business and philanthropic life. In an 1807 census of the almshouse, more than half of its inmates were immigrants (71 percent of the male and 58 percent of the female patients).² This was typical of almshouse inmates; in 1796 only 102 of New York City's 622 almshouse residents were American-born (Carlisle, 1893). The Philadelphia almshouse population remained overwhelmingly poor and disproportionately alien; a census of 1821 showed that 43 percent of the inmates were foreign-born; in 1840–41 the figure was 46 percent and a decade later it had risen to 68 percent (Clement, 1977).

Even by contemporary standards, almshouse conditions were brutal and the distance between patients and their physicians vast. The minutes of Philadelphia's late-eighteenth-century Overseers of the Poor underline these particular realities. On the 20th of January, 1797, they noted that a patient had been sent to the Pennsylvania Hospital "at the charge of this Institution with a broken jaw occasioned by a stroke from Dr. C." The costs implied a dilemma. "Quere? Ought Dr. C not be prosecuted as it is thought he is liable for all damages?" Some months earlier, they could reflect with some whimsey on the fate of "John R.*** noted dirty worthless customer, noted as a tender or waiter among the Fish sellers, etc. etc. and also among the dirty hussies by the name of 'Cock Robin' and they have now cooked him up indeed or fully and fowly done him over, he being highly venereal" (Hunter, 1955). This was indeed a personal stewardship exerted by the Overseers of the Poor, but one rather less pious than that exerted by the Friendly Board of Managers at the Pennsylvania Hospital; "Cock Robin" would never have been admitted to the board and care provided at that private institution.

Admission to an almshouse ward—even for unavoidable illness or injury—was a confession of failure. For both the institution's internal

² *Philadelphia Almshouse Census for 1807*, Philadelphia City Archives. Hereinafter archival materials from this repository will be cited in brief form. For a complete description of materials relating to Philadelphia General Hospital, see the appropriate sections in Daley, 1970.

order and its process of recruitment mirrored closely the values and relationships that reigned outside its walls. Most significant was the unavoidable blurring of the distinction between sickness and dependence, for in fact the primary requirement for admission to an almshouse ward was dependence, not some particular diagnosis. Those Philadelphians who could be treated at home obviously preferred such outpatient care to the stigmatization of becoming an "inmate" (the term was used into the present century) in an almshouse. It was at once refuge and punishment for the morally and physically incapacitated, for the alcoholic and the diseased prostitute or sailor, as well as for the longshoreman or teamster who might have been injured at work.

In the categories of popular social understanding, hard-working and church-going citizens did not belong in the company of paupers, prostitutes, alcoholics, and the dependent generally; indeed, a significant motivation in the founding of private hospitals and dispensaries was that very desire to maintain the distinction between the hard-working worthy poor and the almshouse's appropriate pauper residents (Rosenberg, 1974). Philadelphia's Overseers of the Poor supported the work of "outdoor physicians" partially at least in the hope that their home-visiting would serve to keep their patients outside the morally debilitating walls of the almshouse. In practice, of course, there was often nowhere else for them to go. Private hospital beds were limited in number throughout the antebellum years and hedged in by admission rules that excluded many potential patients—the chronic and incurable, children, sufferers from contagious ills. And in the first half of the century especially, private hospitals in effect excluded those without a place in the community's structure of deference. It was no more than fair for the city's Guardians of the Poor to characterize the Pennsylvania Hospital in 1804 as "shut against the poor" (Williams, 1976).

The difficulty of distinguishing the sick from the dependent, the unworthy from the worthy recipient of public assistance remained as ill-defined within the almshouse itself as it was in shaping admission to it. Were the occupants of the "old ladies" ward dependent or sick? Should they be considered a part of the hospital—or of the "outwards," the term used to describe that portion of the institution assigned to paupers well enough to work? The decision was determined as much by the accident of circumstances as by the application of clear and

universal criteria. If hospital beds were crowded, the sicker among the old people would of necessity be treated in the outwards; if beds became available, the same people might be removed to the hospital. As medical men were all too aware throughout the century, no neat distinction could be made between such cases. Late in 1884, for example, the Board of Guardians Hospital Committee resolved that all persons occupying beds in the hospital who no longer needed care be removed if they were not serving as nurses; a month later, the crowding had not abated and the hospital's resident was instructed to move certain chronic and semichronic patients (such as those suffering from superficial ulcers) to the outwards. It was only natural that house officers should have protested against the recurring need to treat acute cases in the outwards.³ Chronic illness and geriatric debility remained the peculiar burden of the municipal hospital; it was a reality that no increase in medical sophistication and autonomy could solve. Indeed, as the voluntary hospitals came to define themselves in terms of acute illness and timely therapeutic intervention, the role of chronic ailments grew only the more prominent in municipal hospitals.

Another characteristic difficulty for the municipal hospital lay in the distribution of authority. What were to be the respective roles of layman and physician? Were physicians or public officials to dominate the hospital's internal order? The relationship between a politically appointed governing board and the physicians who did their bidding was almost certain to be a stormier one than that between the trustees of voluntary hospitals and their appointed medical staffs. The social ties between lay board and medical board were more likely to be close at the voluntary hospitals. Lay members of municipal hospital governing boards were—from early in the century—men of a rather different sort. Though the mechanisms through which such positions were filled varied, they tended to reflect much closer ties to Philadelphia's political process—and to be filled by men of lower status than those who served the Pennsylvania or Episcopal or later the University Hospital. As we shall emphasize, the last third of the nineteenth century was a period that saw a steadily increasing role for medical men and medical needs in the municipal hospital; nevertheless, the values and priorities of the medical world were never to

³ Minutes, Hospital Committee Board of Guardians, December 12, 1884, January 16, 1885.

entirely shape the wards of a Philadelphia General or a Bellevue Hospital. The almshouse heritage and the very magnitude of the need that filled their wards guaranteed that an enormous gap should separate private and public hospitals in our older cities.

The Almshouse Heritage: a Society Writ Small

Like any social institution, the almshouse-hospital was obviously a microcosm of the social values, structures, and careers which characterized the larger society outside it. Perhaps the most important and unavoidable reality was the public image enjoyed by the institution; despite the fact that it had been in function and reality essentially a hospital throughout the century, it never occupied that morally neutral niche in the public mind. The hospital's resident physician made precisely that argument in 1856 when he emphasized that the so-called almshouse included within itself a smallpox hospital, a lunatic asylum, a children's asylum, a lying-in department, a nursery, a hospital for medical and surgical cases, and wards for venereal and alcoholic cases "besides the Almshouse properly so called which is in reality an infirmary for the blind, the lame, the superannuated, and other incurables so decrepit as not to be able to earn for themselves a livelihood." The number of able-bodied, he continued, was in reality quite small and consisted largely of the casual criminal and vagrant who alternated between prison, almshouse, and "low dens of vice"; it was their presence, he concluded, that brought a stigma upon the sick and unfortunate, "which would not attach to them if this place was in name, and, in the opinion of many in the community, what it is in reality, a hospital" (Lawrence, 1905).

Though the almshouse did not formally subscribe to the principle of less eligibility—a widely accepted policy which dictated that conditions within the almshouse for the well pauper always be less desirable than those he or she might find outside—its governors were still committed to the need for providing, and demanding, work from those able to perform it. Thus surgical patients were expected to pick oakum as soon as they were well enough to walk to the "Manufactory."⁴ The most frequent form of work, however, was as nurse, or

⁴ Minutes, Hospital Committee, June 29, 1842.

assistant in the hospital and asylum. In 1849, the Board of Guardians stated that of 756 male paupers in the house, 449 were hospital patients and 67 employed as nurses; it left comparatively few of the "able-bodied" for whom "useful employment" had to be found (Philadelphia, 1849). And, in fact, several years earlier the board had closed their "House of Employment," sold the machinery on which inmates had worked, and converted the building into more hospital space. And, as we shall emphasize, even those inmates capable of some small amount of work were in many cases able-bodied only by the kindest of definitions.

Patient Population

Not surprisingly, average lengths of stay were always longer in Blockley (as the almshouse came to be called after it moved in 1834 to a then rural area in West Philadelphia bearing that name) than in its private peers. Similarly, death rates continued to be high throughout the nineteenth century and into the twentieth; the municipal hospital was always the recipient of those cases for which neither recovery nor remission could be hoped. Similarly a far greater number of male than female patients filled its wards—and among the males a disproportionate number were single or widowers. A man with a place in the community would not ordinarily have found his way into the almshouse unless the victim of a lengthy and debilitating illness or old age itself. Such considerations applied even more strongly to women; it was disgraceful to allow a mother or sister, or even a domestic servant, to enter a hospital or almshouse. As late as 1879, a house officer noted that "nearly all the fracture cases in the house at the present time are old maids, no doubt due to the fact that when one of these unfortunate beings meets with such an accident her kin are anxious to get rid of her, while if a mother or wife is so unfortunate, her husband or child will take care of her at home" (Flick, 1944).

Long convalescences and a large proportion of "old men and women" underlined the difficulty of distinguishing in practice between the recipients of care in the hospital and alms in the institution's outwards. The hospital's clerk noted in 1864, for example, that a good many patients had actually been treated in the outwards, "especially upon the female side, where many of the old women are so comfortable, that it is with great difficulty that they can be prevailed upon to go to the hospital." Such practices, the same officer noted four years

later, were almost unavoidable for there was often an inadequate number of acute beds in the hospital. And the distinction between acute and chronic was sometimes as difficult to apply in practice as that between the sick and the simply debilitated; a decade later, the Board of Guardians' Hospital Committee was warning its medical staff not to treat acute diseases in the outwards for longer than 36 hours.⁵ Many almshouse patients were "regulars," readmitted again and again before ending their days in its wards. John Miller, for example, a Scottish-born fifty-year-old blacksmith died and was autopsied in the almshouse in 1864. Miller was described as intemperate. His health had been good until mid-1862 when he was admitted with cramps in his legs which he attributed to a "debauch" and sleeping outdoors. Four months after that he was admitted again as a drunkard and sent this time to the drunkard's ward instead of to male medical. He was then transferred to medical to be treated for a cough that hinted at incipient tuberculosis. In the spring he was sent to the male outwards where he assisted in making iron bedsteads. In August he left the house "on liberty," but returned in early October complaining of a severe pain in his leg. The limb became livid and Miller died a few weeks later.⁶ Only the comparative rapidity of Miller's physical deterioration set him apart; otherwise his life was typical of that of the working men who filled so large a proportion of Blockley's beds.

Admissions, significantly, had to be certified by an agent of the Board of Guardians; only when the patient entered the almshouse did its medical staff play a role in assigning him or her to an available (and if possible appropriate) ward. Discharge perhaps even more than admissions incorporated social as well as biological dimensions. In mid-century, for example, hospital patients who were not natives of Philadelphia were often discharged with fare sufficient to return them to their place of birth or previous residence; prostitutes were ideally discharged into the hands of an employer or society for the reform of "fallen women"; illegitimate children and their mothers might not be discharged until an effort had been made to find the financially responsible father. Such realities changed only in detail during the

⁵ *AR for 1864*, p. 42; *AR for 1868*, p. 52; Minutes, Hospital Committee, March 1, 1878.

⁶ Casebook, Male Medical, 1864-1869, p. 5.



Corridor in a "Pauper's" Ward

course of the century. In 1883, for example, the obstetric staff recommended that women be allowed to stay only three months after confinement; and the children treated at the children's asylum were in practice the residue of orphans and chronic cases who could not be placed in an appropriate home; they were, in the words of the "children's visitor" in 1884 "deformed, crippled, diseased eyes, nervous, etc. These children are not acceptable or desired as boarders at private homes, nor, indeed, could they get, in private homes, the constant nursing and medical care which they receive in the Children's Asylum."⁷ Were these children a medical or a welfare problem? To phrase the question is to admit its meaninglessness. Such problems could not easily be solved. As late as 1898, for example, one duty of the nurse in the venereal ward was to make sure that discharged patients were issued shoes.⁸ It was difficult indeed to apply strictly medical criteria to any stage of the patient's experience—admission, care, or discharge.

Within Blockley, of course, factors other than the biological or the narrowly economic also helped shape an inmate's experience. The deviant and the low in status—prostitutes, alcoholics, the black, and the aged—fared particularly badly even in an institutional context in which no one fared particularly well. And all inmates, including nurses, servants, assistant nurses, and house officers, were subjected to a paternalistic discipline throughout the century, one that mirrored more general assumptions about the appropriate responsibilities of the several social classes.

Female venereal cases were a particular thorn in the sides of generations of administrators and physicians. Almost all, of course, were prostitutes and their incarceration as much penal as therapeutic. They were made to work whenever possible and the resident physicians given special powers to discipline these bawdy and unremorseful objects of municipal benevolence. Their diet was almost invariably worse than that of other medical patients; in the 1820s, indeed, it was explicitly ordered that they be fed the same diet as that offered healthy paupers, one designed explicitly to discourage extended almshouse stays. This double standard continued throughout the century. In

⁷ *AR for 1884*, p. 20.

⁸ C.G. Dalbey to G.O. Meigs, July 11, 1898, chief resident's letterpress copybook, p. 438.

dress, in freedom of movement, even in the right to borrow library books, venereal patients found themselves treated very differently from their fellow patients with less stigmatizing ills. Visitors were always carefully limited—in part as an aspect of the ward's punitive character, in part because of the fear that prostitutes might seek to ply their trade on a retail basis within the hospital's walls. Venereal patients at the end of the century were assigned blue bedspreads while all the other patients were issued white spreads; employees working in the venereal wards were asked, moreover, to change their clothes before eating in the staff dining room.⁹

Even within the venereal wards, physicians worried constantly about the need to maintain moral distinctions. One of the great problems, as contemporaries saw it, in both venereal and lying-in wards was the danger of contaminating erring but still salvageable females. In 1865, Blockley's clerk recommended that the female venereal ward be divided into two, "one for abandoned characters, the other for those admitted the first time, many of whom show a willingness to reform; and if the immoral and debasing influence of those who are almost continual residents of the ward could be prevented, a small proportion, at least, might become useful members of society."¹⁰ A decade later, a prominent physician demanded a similar division in the lying-in wards. "Lying-in hospitals," he conceded, "are never schools of virtue, but if their inmates leave them morally worse than when they entered, we are bound to ask whether this sad result could not be prevented by some practicable change" (Ray, 1873).

At Blockley one of the amenities offered even the most humble was racial segregation; even paupers, it was assumed, deserved to be segregated by race and sex. (Revealingly, this was true for all but venereal patients.) Black patients were always present in nineteenth-century Blockley (and often in numbers greater than their proportion in the population), and routinely occupied the least desirable wards. In 1846, for example, when the hospital needed more bed space for "lunatics," patients were removed from the black male medical ward to the attic.¹¹ The attics were, of course, the most unpleasant part of the institution,

⁹ Hospital Committee, August 12, 1859; Hospital Committee, January 22, 1886; Memorandum, acting chief resident, October 27, 1902, chief resident's memorandum book, p. 93.

¹⁰ *AR for 1865*, p. 50.

¹¹ Hospital Committee, January 28, 1846; Clement, 1977.

cold in the winter and stifflingly hot in the summer. A generation later, the "colored wards" were still in the attic. "Those wards are unfit for the care of any sick people," a reformist member of the Board of Guardians charged in 1873, "but they are used solely for the reason that there is no other room for them; every other available spot being occupied . . . The house was not built with the intention of having the attics used for wards, consequently they were not furnished with flues for the admission of hot air from the furnaces." A medical man added that the ward was not over twenty feet wide and the ceiling no more than eight feet in height—the beds crowded closely together and the inadequate ventilation provided by several windows two feet long and eighteen inches high (Ray, 1873). But given the social assumptions of most nineteenth-century Americans (even in Quaker-influenced Philadelphia) such segregation was only to have been expected.

The treatment of alcoholics needs even more explanation, for they occupied a gray area between that of the legitimately (morally neutral) sick and that occupied by the culpable offender. True, the alcoholic might not be immediately responsible for his actions—even for the delirium tremens so dangerous to himself and destructive to hospital routine—but he was ultimately responsible for the decision to drink, which over time brought about his addiction. And alcoholics were ordinarily brought in by the police or committed by magistrates; in an administrative sense they were inmates indeed. Most of the inhabitants of the "men's drunkards ward" (as it was called in official reports) were diagnosed simply as "debauch"; in 1873, 530 of 585 and a year later 440 of 457. Only the handful of patients diagnosed as suffering from delirium tremens were actively treated. Within the hospital, they were at first placed in cells with a keeper, not a nurse. Only in 1848 did the Board of Guardians' Hospital Committee vote to change the name of "drunkard's cells" to ward; a year later they resolved that these wards were now part of the hospital and no longer part of the outwards, and the keeper's duties were to be performed by a nurse and an assistant nurse.¹² The location of these wards and the activities that went on in them had not changed, but had begun to be viewed in a new framework of perception. The alcoholic's

¹² *AR for 1873*, p. 69; *AR for 1874*, p. 57; Hospital Committee, September 29, 1848; April 20, 1849.

dilemma was physiological as well as moral; no medical man doubted, no matter what the drinkers original responsibility, that delirium tremens could and often did kill, and was especially dangerous to inmates thrown untreated and unattended into cells to sober up.

In Blockley, and in every other nineteenth-century municipal hospital, discipline was tenaciously sought. As late as 1896, an editorialist reminded readers that "a difficult and discontented class in the community is being cared for," in public institutions, and "discipline is so absolutely necessary to the success of management."¹³ In antebellum Blockley, patients confronted a wide variety of rules and punishments. The *Rules* of 1822 specified, for example, that paupers who failed to work or who acted in a disorderly or disrespectful manner could be placed in the lunatic cells and fed on bread and water. Through the middle third of the century, unruly inmates could be placed in punishment cells, given forcible cold showers, and have their normal diet curtailed. In December of 1846, for example, the Hospital Committee of the board ruled that Caleb Butler "be kept in the cells on Bread and Water for 48 hours, and soon as the Physician in Chief says his health will permit, he is to receive one shower bath per day for one week, and two Shower Baths per day for two weeks—Making 3 weeks—Subject to the Order of the Physician in Chief."¹⁴

The Hospital Committee had to be careful indeed in seeking to oversee such punishments, for house officers seem often to have preferred a casual blow. Many of the hospital patients were ambulatory and their movements had to be carefully controlled; passes had to be obtained before a patient or nurse could go on "liberty" and harsh punishments awaited those late in returning. Patient mobility within the institution had to be carefully constrained as well. The separation of male and female patients was a particularly difficult problem; gates between the male and female hospitals tended not to stay closed and blinds had to be placed on the windows of the men's wards to keep patients from conversing with their female counterparts.

Perhaps the most fundamental aspect of discipline was the work—often meaningless and repetitive—that all but the most debilitated were expected to perform. As Blockley's steward explained it in 1875,

¹³ *Boston Medical & Surgical Journal* editorial, Boston Public Institutions, 135:422.

¹⁴ Hospital Committee, December 11, 1846.

the work was not only valuable to the institution in a period of lean budgets, but was "beneficial" to the patients, "and has enabled me more easily to preserve proper order and discipline in the management of the institution."¹⁵ To find refuge or work in an almshouse was to surrender a citizen's normal autonomy. Paternalistic rules applied to nurses, house officers, and minor functionaries as well. Enforcement was often erratic, but the institution's right, indeed duty, to demand strict discipline was unquestioned.

Impressionistic evidence indicates, however, that the Blockley reality was a good deal less ordered than such rules might have implied. Throughout the century, for example, there seems to have been an irrepressible black market in alcohol and a brisk trade in pilfered food and drugs. If the steward placed blinds on the patients' windows, the men persistently removed them and used the windows for the disposal of trash, bottles, and other "offensive matter."¹⁶ The mixture of prostitutes and political appointees made for another chronic moral lesion. And discipline implied an orderly chain of command and predictable patterns of punishment; here again order was elusive. House physicians, for example, were a difficult and often unruly lot, resentful both of their senior attending physicians and of the laymen who in theory administered the institution. They provided a weak link in any chain of disciplinary command.

Public and Private Hospitals

A good many of the same social values and relationships of status and deference were present in voluntary hospitals, but the differences between public and private hospitals was always marked in nineteenth-century America. In fact, that very difference was a fundamental aspect of the municipal hospitals. First, as we have seen, the almshouse-hospital was always a last resort; patients were unwilling to apply for admission until driven to desperation; the creation of private outpatient dispensaries and the ministrations of municipalities' own "outdoor physicians" were not simply humanitarian gestures, but were seen consciously as a rational (and economical) means of saving the worthy poor from the degraded status of almshouse inmate. The ability

¹⁵ AR for 1875, p. 27.

¹⁶ Hospital Committee, January 23, June 26, 1863.

of the voluntary hospitals to pick and choose among their cases—and the corresponding need for the almshouse-hospital to serve as the refuge of last resort for the tubercular, the chronic, the alcoholic, the moribund—meant that Blockley inevitably served as a dumping ground for such cases—often, indeed, transferred there when the patients proved disruptive, did not respond to treatment, or, even more scandalously, were in extremis.

Within the medical profession, as well, municipal hospital appointments tended to be a bit less desirable than the corresponding appointments at private hospitals; the rough social environment as well as the prevalence of chronic and “uninteresting” cases could discourage the youthful practitioner. “The diseases are not of a very varied character,” one wrote in 1840 as he began his Blockley apprenticeship. “The indolent ulcer is by far the most common presenting few or no varieties and generally the result [sic] accidental injuries inflicted upon broken down or vicious constitutions, a few fractures & a tolerable display of hernias, contusions, and diseases of the spine completing the list” (Kane, 1840–41). The lay steward and political appointees who dominated the almshouse were also less congenial than their counterparts in the city’s more prestigious private institutions. Only the scarcity of hospital appointments and the sheer volume of “clinical material” allowed Blockley to compete effectively for the services of young house officers.

Not surprisingly, conditions at municipal hospitals generally and at Blockley in particular were often far below the standards tolerated at private institutions. Throughout the century, well-meaning Philadelphians found conditions at Blockley a scandal. Diet, accommodations, and washing facilities were chronically inadequate and the subject of recurrent demands for reform. Nurses in 1859 were charged with seeing that the straw in the beds was changed “at least once in each month during the summer season, and see that the beds are preserved free from vermin.” They were also to see that patients changed their linen at least once a week. How closely these worthy injunctions were followed remains unclear. Penury and corruption inevitably lowered hospital standards. In 1844 nurses were warned against tearing up shirts to provide needed bandages. Two years later a request for a bathtub in the “operated ward” was rejected because of the expense. Doctors found themselves without lancets—still considered a necessity—in the 1850s, while the eminent surgeon Samuel

D. Gross complained in 1862 that scurvy was endemic in the hospital.¹⁷ (And physicians had known for well over a century that fresh fruits and vegetables were preventive.) But conditions did improve—if at a somewhat glacial pace. In 1870, Blockley's steward could report that the bathtub in the woman's bathhouse had been enlarged by almost a half—and could now accommodate about a dozen patients at one time! A year later, it was suggested that the lying-in department be furnished with a water closet, hot water, and wash basins. Nurses had complained the previous year that the roof leaked so badly that a good many patients had to be moved during every rain storm. A few months later—in December—a prominent attending physician could complain that ward temperatures were dangerously low and the supply of blankets inadequate.¹⁸ Until the end of the century, conditions were crowded and patients stowed in rooms which had never been designed for human occupancy. Convalescents as well as blacks were isolated in attic rooms, for example, and as late as 1887, the Department of Charities (the new-model title of the Board of Guardians of the Poor) could complain of "the fearfully overcrowded condition of the Hospital attics appropriated to the so-called convalescents from the men's medical and surgical wards . . . When the beds are prepared for the night there is barely room enough left to enable one to walk from one of the rooms to the other. Many of the patients are compelled to sleep two in a bed."¹⁹ The details shifted, but the fundamental reality changed only in degree throughout the century; conditions at Blockley were always forbidding and always worse than those that prevailed at Philadelphia's private hospitals.

It is hardly surprising that working men and women, even the most helpless, showed little willingness to enter the almshouse. A spokesman for Pennsylvania Hospital put the distinction between public and private with unavoidable clarity; the Pennsylvania Hospital, he explained in 1867,

is the house for the better class of our poor, when sick or wounded; the abject poor finding a refuge in the Blockley Hospital of the Almshouse.

¹⁷ Board of Guardians, *Rules*, 1859, p. 61; Minutes, Board of Physicians, September 9, 1840; Hospital Committee, October 23, 1844; April 15, 1853; January 26, 1855; March 14, 1862.

¹⁸ Hospital Committee, February 25, March 4, 1846; September 6, December 27, 1872; *AR for 1870*, p. 28; *AR for 1873*, pp. 31–32.

¹⁹ *AR for 1887*, pp. 10–11; *AR for 1888*, p. 6.

Now, I think no person comes in here thinking to carry away spot or blemish connected with the fact of a sojourn made in our house; for no man nor woman is forced by the mandate of a magistrate or the constraint of a constable.

When a group of mid-century philanthropists sought to establish a hospital in Philadelphia they had only to cite the almshouse as motivation for the creation of such an institution—not a reason to make it unnecessary. The almshouse, they emphasized,

is necessary, but while it is the legal receptacle for all whose destitution is the result of idleness, profligacy, and licentiousness, it communicates a character to its inmates which causes those who have any remaining feeling of respect for their own reputation, or that of their children, or connection, to be willing to endure, to the utmost limit of possibility, all the evils of sickness and poverty rather than submit to the stigma which attaches to those who enter its walls (Episcopal Hospital of Philadelphia, 1851).

Such assumptions did not easily change; thirty-five years later, Philadelphians employed remarkably similar arguments when a group of Methodist laymen sought funds to establish a Methodist Episcopal hospital. Blockley, a prominent medical man argued, “is not worthy to be called a hospital. It is nothing but a part of the Almshouse; its inmates are stigmatized as paupers; it is in improper buildings and the pure and impure are mingled indiscriminately together.” There was not a voluntary hospital bed, Dr. Wood emphasized, in the entire city, “in which a poor man or woman, without influence, can feel sure of being cared for in the hour of trouble.”²⁰

Chronic Disease

The problem was not sickness alone, but chronic illness, for it was such cases that private hospitals felt unwilling or unable to admit and which filled large numbers of long-term beds at Blockley. As late as 1887, for example, the census at Blockley was 1200—while the Pennsylvania Hospital was treating only 164 patients. “We have of classes that the Pennsylvania Hospital cannot receive for want of means,” the Blockley authorities emphasized, “568 chronic or incurable cases, such as consumptives, paralytics, epileptics, and patients

²⁰ *Philadelphia Public Ledger*, Dec. 17, 1886, p. 1.

with cancer."²¹ The problem of chronic disease was apparent throughout the century. It was one of the motives in the founding of Philadelphia's Episcopal Hospital (and New York's St. Luke's as well). "It is a well known fact," a committee of the new Episcopal Hospital's medical board reported in 1858, "that there exists in Philadelphia no place excepting the Almshouse to which the poor afflicted with chronic incurable diseases are admitted. To the Almshouse the more respectable class of them entertain an intense aversion & unless compelled by the direst necessity never resort. Everyone who has mixed among the poor has noticed this, and it cannot be doubted."²²

But if the pious low-church Episcopalians who staffed and administered Episcopal Hospital could not help feeling concern for the chronically ill, most of their medical contemporaries were anxious to keep such long-term sufferers out of hospital wards. In Boston, for example, the Boston City Hospital was in theory to be established as a separate hospital so as to allow the poor to be treated outside the stigmatizing walls of the almshouse. Yet as one strong advocate of the new city hospital argued, it was necessary that it only admit patients suffering from acute ailments. The costs, added to the problem of overcrowding, "imperatively forbid the admission, into a hospital, of patients who can be equally well cared for in an almshouse. The object of hospitals is to treat disease, not to afford an asylum for the idle or decrepit" (Green, 1861). The stigma of charity and the burden of age and chronic disease were never to be solved; even within the almshouse itself, the aged and helpless were the least desirable. Just as the city's private hospitals sent their chronic patients to Blockley, so the aged and particularly feeble within the city hospital were transferred to the "insane department."²³

Work Within the Walls

The municipal hospitals were in many ways a world unto themselves. With much of its labor recruited from one-time inmates, the hospital was not only a reflection of the larger society's values and priorities, but also a distinct and self-contained work culture, centering on a

²¹ *AR for 1887*, p. 10.

²² Minutes, Medical Board, Archives of Episcopal Hospital, Philadelphia, April 23, 1858.

²³ *AR for 1868*, p. 49.

“job ladder” and dominated by the influence of long-time employees. Throughout the century, administrators had bewailed the problems created by the use of inmate labor—alcoholism, pilferage, incompetence. As early as 1825, the almshouse medical board had asked that a “regularly trained” nurse of good reputation be assigned to each ward, but warned that this could not be done without an increase in salary. A decade later, the Board of Guardians bravely resolved to hire no more nurses from among the pauper inmates and replace those presently employed with “persons of known integrity and steady and temperate habits.” Significantly, the original resolution had included the phrase “and assistant”; but even in a reform mood, the board realized that it was unrealistic to hope that they could find sufficient funds to hire assistant nurses. The reference to assistants was stricken from the minutes.²⁴ It was not until the last decades of the century that such goals could be considered more than well-meaning rhetoric. And of course much of the common labor, cooking, butchering, laundering, carpentry—even the compounding of prescriptions—was performed by inmates. Nursing was little differentiated from other inmate tasks.

Or at least assistant nurses. For one can discern traces of a career line at Blockley, one in which patients might first work as they recovered, then stay and work for board and room as assistants, then gradually be paid, first with plugs of tobacco and alcohol, then clothing, then a small monthly salary. Finally, through skill and reliability (and possibly political connections), he or she might be promoted to ward nurse. A few workers could rise even higher in the hospital hierarchy. John Miller was not only a ward nurse, but cupper and leecher (for which he received extra pay). Frank Johnson, another ward nurse, achieved even more authority. He was put in charge of Blockley’s surgical instruments and physicians had to request them from him; Johnson also supervised the cleaning of the grounds and was subsequently given charge of issuing all the hospital’s alcohol.²⁵

It was only to have been expected that these positions, and especially the supervisory ones, would become enmeshed in a web of political patronage. One mid-century nurse who killed two patients by giving

²⁴ Minutes, Board of Physicians, March 7, 1825; Minutes, Board of Guardians, September 7, 1835.

²⁵ Hospital Committee, December 6, 27, 1861; March 8, May 24, 1872; August 29, 1873; February 27, 1874.

them the wrong drug—while he was drunk—was only suspended for a week. Even more egregiously, a Mr. Lane who was in charge of the receiving ward was brought up on charges ranging from disobedience toward the steward to “ungentlemanly” conduct toward a lady; at one hearing he insolently repeated his inappropriate language in front of the Board of Guardians’ Hospital Committee itself. Still, it was not until more than four years after this incident that Lane was replaced; and by a man to be paid less than half Lane’s \$18.00 a month salary. Lane must certainly have had influential friends and protectors.²⁶ Such mundane ties only strengthened the hospital’s localistic and antiprofessional ethos. It was a community of like-thinking fellow workers who fought back aggressively when in the 1880s the Board of Guardians engaged a Nightingale-trained superintendent for their nursing school; her administrative control over graduate and student nurses recruited from outside the institution represented an immediate threat to Blockley’s well-established social order.

It was only natural that the young physicians who served as house officers should often have walked Blockley’s grim wards like officers of an occupying power. “The doctor must be wary,” one resident wrote in 1877, “if he wants to have control of his wards, for the vicious and often criminal elements therein will stop short of nothing to circumvent him” (Roberts, 1877). The resident’s impressions were only typical. The Blockley experience could be traumatic for such protected young men. And, unlike their patients and aides, these educated and self-conscious practitioners sometimes recorded their impressions. Fortunately, two such young men kept journals in the early 1880s; their experiences are both illuminating and significantly parallel. Most striking is the ambivalence they felt toward their charges. They seemed a very different sort of person from those they had grown up with. A.A. Bliss (1916), for example, one of these physicians, described the patients in his obstetrics ward as

women with their first children, young, ignorant, without any self-control, sometimes with instincts and manners like savages. Of course very few of them were married. In rare instances, the mothers manifested a real and lasting interest in their children, but usually the feeling was an evanescent, physiological, maternal instinct, not

²⁶ Hospital Committee, October 1, 1852; August 16, 1850; January 10, 1851; October 14, 1853; January 27, February 3, 1854; May 4, 1855.



Resident Staff at Blockley, 1892

as deep or as serious as a cat would feel for its kittens, or a cow for its calf.

The same young man was astonished while on ambulance duty to see the kindness and helpfulness shown by his patients' tenement neighbors. "I was among the lowest of the low," he reflected, among "people so wretchedly poor, that in Philadelphia, the city of cheap homes, they housed or rather kenneled in this rotting tenement. I don't suppose they knew much of the fine distinction between right and wrong . . . I strongly suspect that, like beasts, they lived in promiscuous intercourse, but a wave of emotionalism or, perhaps divine pity, swept over them." It was a structured relationship that degraded in their different ways both physician and patient. "After living in such circumstances," Dr. Lawrence Flick (1944) recalled, "we became naturally overbearing, dogmatic, and it must be confessed, more or less brutal."

Material conditions within the hospital only mirrored such emotional brutality. Flick noted in January of 1880 that it was no wonder his patients were infested with lice, since they had no change of clothes and no adequate bathing facilities. For three months they had been short of linen; if a woman's nightshirt needed to be washed they would have to send the clothing out to be washed and keep the woman in bed until it was returned. Food was consistently poor in quality: eggs rotten, the cold meat doled out in infinitesimal portions, and the sugar used in the nursery "looked like sawdust soaked in some brown fluid." And patients were, of course, expected to work as soon as they could; Flick spoke with uncharacteristic warmth of an uncharacteristically "respectable" young girl who had given birth one evening at ten, been thrown out of her step-father's home—and who was at work on a Blockley sewing machine the next day.

Though many of the patients seemed unsympathetic—paupers who failed to show a humility appropriate to their station—others seemed victims of a system that demanded a poor man's dignity in payment for a hospital stay. The presence of the almshouse, as young Dr. Bliss noted, made any poor but respectable Philadelphian unwilling to apply for hospital admission, except as a last resort. And when they were driven to apply, he learned gradually, medicine and medical men were perhaps less understanding than the political functionaries who represented the city's Board of Guardians of the Poor. As Bliss

recalled, the Guardians owned a small house on Seventh Street (in central Philadelphia, several miles from Blockley) where applicants for hospital or outward admission were examined by a hospital resident in conjunction with a lay official of the board. "It must be confessed," Bliss concluded, "that the young medical man was often too disposed to be sarcastic, cynical, suspicious, and anxious to drive away every applicant who did not bear in his or her body the symptoms of being an interesting medical or surgical case." The city's political appointees, on the other hand, were sympathetic, never spoke harshly to the supplicants who appeared before them, and often admitted them, even when the resident decided that they were not sick enough. The categories of medical diagnosis might seem intellectually, and in a sense morally, superior to the imperatives of sordid patronage; they did not always transcend them in humanity.

*Doctors and Guardians:
The Medicalization of Blockley*

Almost from the beginning of the nineteenth century, Blockley's physicians had sought to distinguish the hospital in which they worked from the almshouse. But they were never entirely to succeed. Blockley was becoming more and more a hospital—yet a hospital that could not escape the almshouse aura that had surrounded it since the eighteenth century.

At first the medical presence in Blockley was comparatively small. Senior attending physicians appeared only on "regular prescribing days," and even then might send students or substitutes. But this did not discourage the medical staff from seeking to control medical practice in the hospital. In 1825, they asked to examine all candidates for house physician, although the power of appointment still lay in the hands of the Board of Guardians. Even earlier they had sought to increase the opportunities for postmortems and dissection.²⁷

But in 1834, with the transfer of the almshouse to West Philadelphia—then a green and pleasant area of small farms and quiet settlements—the problem of differentiation emerged in sharper form. A year later, the medical board suggested that the name "Philadelphia Hospital" be used as a proper designation for the building that housed

²⁷ Minutes, Board of Physicians, March 7, 1825.

the almshouse sick. At almost the same time, significantly, the medical staff resolved to admit no one to the medical and surgical wards without an examination, and protested against the continued necessity of treating severely ill paupers in the outwards. (Nevertheless, admissions could still take place only upon a written order of the Board of Guardians' agent.) In return for a continued hold on the hospital's medical administration, the medical board promised to make daily visits and generally place the institution "on a footing with some of the best hospitals in London and Paris."²⁸

Such estimable goals could hardly be attained while the hospital was administered as an almshouse. It was inequitable, the medical argument followed, to both patients and physicians. An almshouse and a hospital should and must be separate institutions. The arguments were reiterated again and again in succeeding decades. In 1873, for example, Isaac Ray, a prominent expert on psychiatry, addressed the self-consciously reformist Philadelphia Social Science Association and affirmed the need to differentiate the two institutions as a preliminary step in providing the city's worthy poor with adequate medical care. Minor improvements, he emphasized, "will fall far short of the end in view, if the hospital is to be managed in the spirit of a pauper establishment. The paramount consideration must be, not how cheaply the patients can be kept, but how speedily they can be cured, and how far their sufferings can be alleviated." Those in the almshouse were the city's legitimate concern, Ray continued, and few of the city's respectable understood the reality of Blockley: "In a continuous pile of buildings, just across the Schuylkill, it has gathered them together, from 3,600 to 4,000 in number, varying with the season, and constituting one seething mass of infirmity, disease, vice and insanity" (Ray, 1873).

What underlined the physicians' appeals was an unmistakable social consensus that assumed the reality and usefulness of the distinction between the worthy and unworthy poor, between the demoralized pauper and the hardworking but unfortunately ailing worker. "I conceive," Dr. Horatio C. Wood added in endorsing Ray's argument, "that there can be no plainer and more sacred duty of a community than that of taking care of its destitute, sick and poor; no greater mistake than that of confounding vicious idleness with the need that

²⁸ Minutes, Board of Guardians, August 19, Nov. 2, 1835.

sickness may bring any day to the poor." Yet the only way a poor man could guarantee himself medical care was to have himself labeled a pauper. "The city must have a municipal hospital," Wood contended, "unconnected with and uncontaminated by association with the workhouse—a hospital maintained purely and solely as such, where the poor man, or woman, or child, can always go, knowing that poverty and sickness are the only needful passports for admission."

The issue did not redefine itself, even as the hospital grew ever more prominent and self-contained. In 1900, for example, Blockley's medical staff again formulated the now commonplace demand. The hospital, they charged,

being a part of the Almshouse, there is strenuous objection on the part of many people to take advantage of the treatment therein accorded patients, because of the stigma of pauperism which they believe is attached to an inmate of the institution.

In order to overcome this feeling your Board desires to separate the two institutions, removing the Almshouse to a suitable location, where the inmates may be properly cared for and yet have some light duties to perform so as to help sustain themselves and to make of the present location a hospital in every sense of the term, one from which the stigma is removed, and that no citizen would hesitate to enter when in need of treatment.

Significantly, this plea was made as part of an effort to "promote, encourage and enlarge the clinical teaching at the Philadelphia Hospital" so as to "make it one of the best medical and dental schools in the world."²⁹ Yet it was not until the 1920s, as we shall see, that the physical separation of the almshouse, hospital, and lunatic asylum became a reality.

Every aspect of the patient's experience reflected the dual system into which he or she entered; sickness and dependency were not easily distinguished. Admission, as we have seen, was certified by a physician and a lay agent of the Board of Guardians acting together (if not precisely in concert) into the 1890s. As late as 1853, visitors to the poor—a kind of protosocial worker—could send patients into Blockley's hospital wards and it was not until 1848 that a smokehouse was

²⁹. *AR for 1900*, pp. 8, 10 (Contemporaries were particularly concerned at the plight of the aged forced to enter an almshouse); *AR for 1887*, pp. 16–17.

converted into the institution's first receiving ward. And this receiving ward was more an administrative than a medically oriented facility; patients were bathed, their clothes stored, but they were not necessarily examined and evaluated clinically. As late as 1880 there was no thermometer in the receiving ward and in 1899 the assistant resident physician could still complain that he kept being called to the front gate to examine patients (presumably emergencies) presenting themselves for admission.³⁰

Once admitted, however, the patient was affected by a medical presence that grew steadily throughout the century. Paralleling physician demands for an explicit distinction between almshouse and hospital were staff requests for more liberal teaching privileges and an increasing differentiation among cases, one reflecting a more general growth of interest in the specialties. Like many other nineteenth-century hospitals, Blockley responded grudgingly, yet inexorably, to medical demands for the creation of specialized services and wards. As early as the 1820s, the almshouse had had a ward for "eye cases," and an accepted distinction between male and female, medical and surgical cases. Venereal patients had, for a number of reasons, always been treated separately. In 1840, the medical staff had urged the creation of a ward for "uterine" disease as useful both to patients and to "medical science." Thirty-five years later, in 1875, staff physicians called for a separate tuberculosis pavilion (though it was a quarter of a century before their request became a reality); and in 1897 they outlined the need for a pediatric department. Dermatology and neurology had been recognized in 1877.³¹ Again, as in most other hospitals, surgery grew increasingly important in the last quarter of the century—though contemporaries noted that it was never as significant in Blockley as it became in its private peers; too large a proportion of its cases were the chronic, geriatric, and contagious ills unwelcome elsewhere. As late as 1900, Blockley's surgical wards housed comparatively few patients who had actually undergone major surgical procedures. The medical staff, nevertheless, worked steadily to keep pace with surgical facilities and procedures of sister institutions. In 1873, Blockley organized a ward for the preparation and recovery of

³⁰ Flick, 1944; *AR for 1891*, p. 58; Gilpin, 1899–1901; Philadelphia General Hospital, *Rules Governing Internes*, 1903, p. 15.

³¹ Minutes, Board of Physicians, December 4, 1826, September 9, 1840; *AR for 1897*, p. 62; Croskey, 1929.

surgical patients; the 1880s had brought "the Antiseptic process," although in a manner so gradual "that it is impossible to fix an exact date even to the year." In 1898 an "anaesthesizer of the Philadelphia Hospital" was appointed.³²

Long-term neurological cases were a particularly difficult problem; they demanded a good deal of care and were unwelcome at all of the city's other hospitals. Blockley staff members made a virtue of necessity and their chronic neurological wards became a center of teaching and research. The evolution of this clinically prestigious situation was complex and instructive. As early as 1866, the superintendent of the hospital's insane department asked that the epileptics "not insane" be removed to the hospital proper (though it seems not to have been done until 1871). A year later, the Guardians Hospital Committee at the request of two of its prominent visiting physicians, moved "that the paralytic ward now embraced in the Out Wards be made a proper hospital ward, with suitable nurses and food." In 1883, members of the medical staff requested that the patients in the "paralytic" wards be removed "to some portion of the Hospital." Four years later, Blockley administrators could announce the erection of two "well-appointed" buildings for male nervous patients; the department had now four nationally prominent visiting physicians, C.K. Mills, Wharton Sinkler, F.X. Dercum, and J.H. Lloyd.³³ Blockley authorities were proud to emphasize that the insane department as well as the neurological work had:

become more truly than ever before an integral part of the Hospital and has been absolutely removed from the category of "asylums:" where restraint or confinement were the chief objects aimed at,—not treatment, improvement, and cure. The services of four eminent specialists in nervous and mental diseases are now given to the inmates of this department . . . The enormous mass of valuable material which these wards contain is being classified, studied, and utilized, primarily for the benefit of the patients themselves, but also for the advancement of medical science and the good of the community.

³² *AR for 1873*, p. 31; *AR for 1890*, pp. 7–8; D.E. Hughes to C. Lawrence, March 18, 1898, chief resident physician's letterbooks.

³³ *AR for 1866*, p. 38; *AR for 1870*, p. 28; Hospital Committee, September 13, 1872; January 19, August 3, 1883; *AR for 1888*, p. 45.

Within the Blockley context, physicians and administrators never doubted that those patients who made up this "enormous mass of valuable material" were far better off in a medically controlled and defined context than in the almshouse outwards in which they had previously vegetated.³⁴

All of this seemed morally as well as administratively appropriate. It was consistent with efforts to allow medical patients to wear clothing different in color and style from that worn by the "paupers." And it was part of a more general movement toward the assimilation of Blockley's overly general and stigmatizing category of inmate into the seemingly more neutral role of patient. Numerically most important were the feeble outward inhabitants, the great majority of whom were in need of medical care. Almost 80 percent of the female inmates in the outwards, the medical staff contended in 1887,

are affected by disease or insanity to such an extent as to make them fit subjects for hospital treatment and care. Many of these belong, as do so many of the hospital cases, to the chronic or incurable class. Most of the remaining twenty per cent of these inmates are frequently the subjects of rheumatic, bronchitic, and other troubles, and almost constantly require medical attention . . . The medical staff strongly urges the desirability of such a modification of the existing classification as would include the women's out-wards under the rules and regulations of the Hospital. This change would involve no additional expense.

Early the next year, this administrative change was put into effect; the matron was replaced by a graduate nurse and the night nursing undertaken by training school students instead of inmate assistants.³⁵

In other areas, the authority of medicine seemed to increase with greater certainty. Blockley offered extraordinarily attractive opportunities for an ambitious and intellectually oriented physician. And from the Civil War to the end of the century, such practitioners lobbied steadily to raise the level of medicine taught and practiced in Philadelphia's almshouse hospital.

³⁴ *AR for 1887*, p. 13.

³⁵ *AR for 1887*, p. 14; *AR for 1888*, pp. 45-46. For the attempt to differentiate clothing of "paupers" from patients, see Hospital Committee, January 2, 1874, May 9, 1884.

Pathology was the first area in which such values manifested themselves. "Morbidity anatomy" had been the key to medical eminence in the middle third of the nineteenth century; and Blockley with its enormous numbers of patients represented, despite sporadic harassment from lay authorities, an excellent place to perform systematic autopsies. William Gerhard, for example, a Paris-trained clinician working at Blockley, was able to demonstrate the pathological distinction between typhus and typhoid fevers in 1836–1837. Similar opportunities at the Blockley deadhouse a half century later helped attract William Osler from Montreal to a post at the University of Pennsylvania (Gerhard, 1837; Cushing, 1925).

With the growing acceptance of the germ theory in the 1880s, and in particular the discovery of the causative organisms of tuberculosis, typhoid, and cholera, the assumed responsibility of the municipality to care for such cases created a demand for appropriate facilities to diagnose and isolate infectious disease. The community's responsibility for contagious ills had a long history; in the eighteenth century, Philadelphia had supported a "pest house" and administered a sporadic quarantine (Wolman, 1974). But the era of bacteriology and immunology meant a new set of options. The possibilities of laboratory diagnosis and subsequent isolation of infectious ills led to the support of a new medical capacity—that of clinical pathology and especially bacteriological diagnosis. It led as well to a gradual integration of the clinical laboratory into the hospital's ward routine.

Blockley had appointed James Tyson as its "microscopist" as early as 1866; and he called immediately for more careful and systematic use of the microscope in evaluating tissues and fluids:

In the present advanced and progressing state of Pathological Anatomy, a condition to which the use of the microscope (especially in its connection with medical chemistry), has contributed more than any other means of modern research, the history of few cases can be considered complete, while in a large number we can scarcely be considered as having performed our duty as physicians, without a microscopical and chemical examination of the blood and more important secretions and excretions of the body.

Brave words. But Tyson also noted that only 17 pathological examinations had been ordered all year in a hospital with an average

census of over 800. By 1883, A.A. Bliss—the youthful house officer we have already quoted—described the pathological laboratory as including “glass pipettes of every size and shape, glass retorts and flasks, test tubes, and many strange and rusty machines long unused and the very use of which were forgotten.”³⁶ The laboratory made slow progress in Blockley’s penurious atmosphere.

Yet by the end of the century, the clinical laboratory was becoming a normal part of hospital routine; the seemingly boundless new opportunities offered by bacteriology had dramatized the need for integrating *all* the laboratory’s results with the clinician’s physical findings. A chief resident’s memorandum of 1897 explained that the junior medical intern was responsible for ordering a chemical and microscopical examination of every patient on his service within 24 hours of admission. In 1903, the hospital reorganized and expanded its clinical laboratory. A year later the laboratory reported having examined 13,542 specimens; by 1906, the number had risen to 22,627, an increase far more dramatic than that in admissions. Two years later, the hospital reported the appointment of a full-time resident in pathology, supplementing the three-month stints of regular medical and surgical residents. The laboratory’s director could in 1904 record with satisfaction that it “has come to be indispensable to the institution.” Research and instruction of house staff had been integrated into the overwhelming volume of routine clinical work. Blockley promised an unlimited field for clinical investigation: “The hospital, presenting as it does, unequalled and almost unlimited opportunity for research work of practical and scientific value, we look upon the present state of development of the laboratory as only the inception of the great work naturally expected in a modern municipal hospital.”³⁷ This was rhetoric directed immediately toward the city council; it would be repeated again and again as staff members sought more adequate facilities.

Similarly, the X-ray was quickly incorporated into the hospital’s clinical routine. The first formal radiology laboratory was equipped in 1900. In 1903, the laboratory was expanded and a director appointed; previously, radiographical work had been performed by an

³⁶ *AR for 1868*, pp. 96–97; *Morman*, 1979; *Clark*, 1933; *Bliss*, 1916.

³⁷ Philadelphia General Hospital, chief resident’s memorandum book, [1897]; *Rules Governing Internes*, 1903, p. 11; *AR for 1903*, pp. 46–49; *AR for 1904*, p. 63; *AR for 1906*, pp. 273–36; *AR for 1908*, pp. 84–87.

assistant resident in his evening hours. The hospital was soon providing therapeutic as well as diagnostic radiological services and by 1910 could boast that its X-ray laboratory's research results "have made the Department known throughout the country."³⁸

By the First World War, at least a dozen specialties had established themselves in the hospital's wards and teaching routine; it was an institution that ever more self-consciously felt itself to be a hospital—and prided itself on the quality of its teaching and care. No physician could ignore the "professional advantages," as the Department of Charities put it as early as 1892, "resulting from official connection with a Hospital of size, importance and character we believe unsurpassed on this continent."³⁹ In 1890, *Philadelphia Hospital Reports* was begun as a vehicle for the publication of clinical studies conducted at Blockley; in 1904, the hospital's annual report included a bibliography of articles in which Blockley "materials" had been used. Philadelphia's municipal hospital was gradually being integrated into the world of medical status and intellect.

Teaching had grown steadily more prominent in postbellum Blockley, and, as it did so, moved gradually from the lecture theater to the bedside. It had, of course, almost always been present. As early as the first years of the nineteenth century, the almshouse attending physicians had made it clear that their service at the hospital implied the right to use the wards for instructing their apprentices. In 1823 they had established a "clinical ward" in which patients for "demonstration" could be kept together; access to Blockley patients was a valuable asset in the prebellum competition for students that enlivened Philadelphia's medical world. The University of Pennsylvania and Jefferson were the principal contenders, but not the only applicants for student access to patients. As a result of hostility between the medical staff and lay board, there was a period of almost a decade at mid-century in which no formal teaching was undertaken, yet the trend was clear. Despite the handicap implied by the lay board's efforts to safeguard patient rights to refuse to be used in teaching, the presence of medical students in Blockley grew increasingly routine throughout the century. By 1891, hospital authorities could report with pride that their medical staff had been offering clinics through

³⁸ *AR for 1910*, p. 46.

³⁹ *AR for 1892*, pp. 11–12.

nine months of the year—to an average audience of 200; the clinics were held on Wednesdays and Saturdays from nine to noon. And that year, for the first time, a student clinic in “morbid anatomy” had been arranged with attendance averaging 150. The tension that had accompanied the provision of teaching facilities in prebellum years had gradually dissipated. By 1901 Blockley could boast that 13,547 medical students had attended at least some of their clinical lectures.⁴⁰

But such amphitheater performances were no adequate substitute for the bedside teaching demanded by educational reformers; it was not until the first decade of the present century that such small-group clinical instruction became a reality at Blockley. But when it was finally introduced, there was little opposition. This increase in bedside instruction brought a decrease in attendance at the show-piece amphitheater lectures that had been such a source of pride (and advertisement) in a previous generation. “While each year shows a diminution in the number of students attending general clinics,” the hospital reported in 1904, “continuous advance is made in bedside instruction and lectures to small classes.” Over 27,000 had attended at least some clinical instruction that year, as opposed to roughly half that number in 1903. A year later the number had risen to almost 35,000 and the Wednesday amphitheater clinics had become obsolete; students would attend only the Saturday morning presentations. The new system seemed advantageous for both student and hospital: “Bedside instruction and ward rounds by students accompanied by members of the staff, have increased and become more thoroughly organized. This method by which the student performs as nearly as may be, the duties of a resident physician, seems to most effectually hold the interest of the student and to have the greatest teaching value.” And the trend continued. In 1909, medical students paid almost exactly 50,000 visits to Blockley; 39,000 were in the form of small-group bedside instruction.⁴¹

The fear of being used as “clinical material” obviously affected almost every patient suffering from anything but the most routine ailment. But teaching was only one way in which the increasing role of medicine affected the patient and the hospital generally. Another

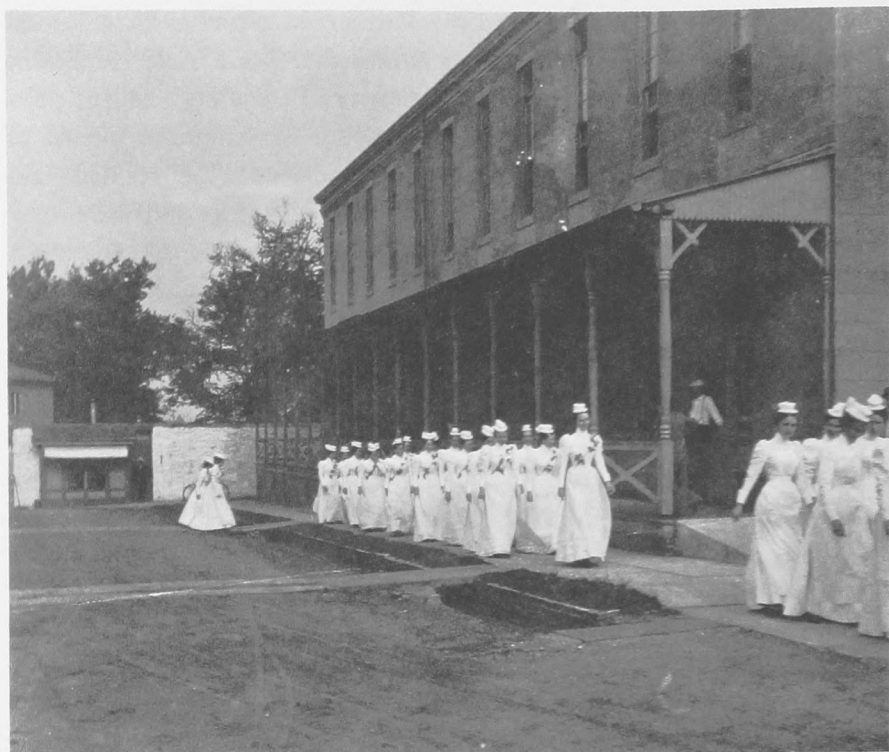
⁴⁰ *AR for 1891*, p. 84; *AR for 1900*, p. 44; *AR for 1901*, p. 32; Agnew, 1862; Middleton, 1933.

⁴¹ *AR for 1904*, p. 52; *AR for 1905*, p. 327; *AR for 1909*, p. 95.

was the development of a medical staff organization with a formal structure and influential standing committees. Even more important was the day-to-day administrative authority of the chief resident physician; created in mid-century as a way of exerting the Board of Guardians' authority, by the end of the century the chief resident had become in effect a chief executive officer. Beginning with authority to make emergency admissions or discharges, he gradually accumulated a measure of control over house and visiting staff, medical care policies, and—in some measure—even the nurse training school. A major obstacle to medical control, however, was the continued authority of a politically appointed lay superintendent who enjoyed general oversight over all Blockley's divisions. Conflict was inevitable, not only in Blockley, but in every American municipal hospital. "The prostitution of the Goddess of Medicine," as one administrator put it, "to the demons of politics is a plague spot on the face of our liberty and republican government" (Goldspohn, 1901). Partially in response to such reformist sentiments, Philadelphia's welfare administration was reorganized in 1903 (its title changed to Department of Public Health and Charities) and an advisory board that numbered among its members some of the city's most prominent and influential physicians was created to work with the department's new director. Despite a lingering political influence, Blockley was becoming administratively more and more a hospital like any other.

Imposing Order

Within the hospital itself, no change was more important than the development of a nurse training school and the assumption of nursing duties by women recruited from outside the hospital. But it was a gradual change and one far more subtle than reformist histories of nursing might indicate. At the end of the Civil War, Blockley was still staffed by a traditional mixture of former patients and a handful of long-term employees. "The present system," the institution's clerk wrote in 1866, "employs irresponsible persons whose only inducement to hold the position is the opportunity it affords to appropriate food and stimulants intended for the patients under their care. Those who are willing to remain as assistants belong to that dissolute class who are unable to keep out of the House, and from whom we can scarcely



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expect a conscientious discharge of duty."⁴² Poor pay and harsh discipline meant that assistants were not only unreliable as to the quality of their ward performance, but also were likely to leave those wards as soon as they could; only a small minority had the character, ambition, or connections to attain the position of ward nurse. Nevertheless, it was not until the spring of 1883, a decade after the establishment of Bellevue's pioneer nurse training school, that the Board of Guardians began to investigate the establishment of a training school; it was not until the next year and with private support that the hospital engaged Alice Fisher, an experienced English nurse-administrator to direct the training school and supervise the hospital's nursing. Gradually the new-model trained nurses made their way into the hospital's wards, first the female medical; finally the male, insane, and venereal wards were brought under their control.⁴³ This change necessarily sharpened the line between patients and attendants; and far more important, it introduced a new source of workers, ones with a carefully cultivated sense of vocational identity and recruited from a class different from the one that ordinarily provided almshouse patients and workers. And as they sought to impose a Nightingale-like order in Blockley—one incorporating moral as well as procedural elements—the trained and student nurses helped create a new atmosphere on the wards. Although the crust of order and professionalism they imposed was often thin, the nurses were in a cultural sense the foot soldiers of an occupying army—of middle-class values, ideas, and personnel in a population which seemed little amenable to such influences.

The nurses were only one element, if perhaps the most important, in a more general bureaucratization of the hospital. It manifested itself in a number of ways; some were significant such as the centralization of cooking, laundry, and medical administration, or the telephone's replacement of the previously omnipresent runners; others were seemingly more trivial, such as the desire to provide uniforms for all staff members visibly marking their function and status. As early as the 1870s, female nurses were required to wear a cap and apron; some time after that male nurses were required to wear a uniform consisting

⁴² *AR for 1866*, p. 59.

⁴³ And not without persistent opposition from Blockley's existing staff; the indomitable Miss Fisher even had rotten eggs thrown through her window. McFarland, 1933; Stachniewicz and Axelrod, 1978.

of "a blue blouse with ornaments according to rank." Nurses and assistants were to display a three-inch Maltese cross on their left sleeve midway between elbow and shoulder. Resident physicians were ordered to outfit themselves in an even more elaborate, military-style uniform: a dark blue cap, coat with two gold bands on the sleeve and a star above it, buttons with the Pennsylvania coat of arms, trousers with gold cord running down the seam.⁴⁴ Order and efficiency were gradually being imposed on Blockley's much older social system.

The Almshouse Enters a New Century

Despite the brave words of reformers and the professional strivings of nurses and physicians, Blockley remained a hybrid of hospital and almshouse as it entered the new century. Almost half its patients were single white males, many "regular customers" who were admitted again and again. A large proportion were immigrants, almost 60 percent in 1892.⁴⁵ Roughly three times as many men as women filled Blockley's hospital wards, a reality that changed little in the years before the First World War. (Significantly, the ratio was three to two for blacks, a measure of the more tenuous social and economic status of the black community and of the exclusionary policies of many of the city's private hospitals.) Death rates, of course, remained high, as they would be expected to in a hospital that could not exercise the option of turning away chronic, incurable, and even moribund patients.

Traditional vagueness of distinction between dependence, sickness, and delinquency remained characteristic of Blockley. A substantial proportion of admissions fell into the categories of venereal, alcoholic, and detention—roughly a third of the patient load in 1902. Even more revealing was the hospital's continuing difficulty in maintaining the line between hospital and outwards; in 1896, for example, 335 men and 124 women were transferred from the outwards to the hospital and 591 men and 146 women from the hospital to the outwards. "These figures clearly indicate," the hospital's annual report had emphasized a year earlier," the close relation existing between

⁴⁴ Hospital Committee, November 13, 1874; June 4, 1875; April 6, 1877; October 19, 1883; May 9, 1884; Nov. 19, 1886.

⁴⁵ *AR for 1892*, p. 34.

the hospital and the out-wards so-called." The fundamental identity between many of the outward and hospital patients continued; in 1906, to cite another example, a year in which the hospital treated 10,057 adult patients, 2339 were "transferred" and 1567 died.⁴⁶ The great bulk of these transfers were, of course, to the outwards—patients too old and sick to support themselves, but no longer sufficiently ill to fill an acute bed.

Even within the hospital, categories of illness remained more discrete in theory than they could become in practice. What, for example, was to be done with "feeble-minded" children and adolescents? "It is hardly necessary to state that they should not be placed in a hospital ward surrounded by the sick but mentally sound; or in the Department for the Indigent, where corruption and demoralization would occur on the one hand, and injury and maltreatment on the other." Venereal patients were still crammed in suffocating attics and, like their deviant peers in the drunk and detention wards, were not allowed to receive visitors without special permission.⁴⁷ Not surprisingly, Philadelphians remained as they had been for more than a century, unwilling to pass behind the forbidding walls of Blockley.

And despite ever-increasing budgetary commitments, per capita costs at Blockley remained far below those of most comparable institutions. In 1907, when the average per diem cost at Philadelphia's private hospitals averaged \$1.81, Blockley expended less than a third of that amount.⁴⁸ A good deal of the work that would now be performed by aides was still being done by convalescent or recovered patients. Ratios of graduates to student nurses varied from year to year, but always remained low. Blockley authorities could complain in 1905 to the city's lawmakers that their greatest handicap was a lack of trained employees: "The most liberal apportionment of workers possible leaves the hospital with less than one-third the number of trained salaried and unsalaried workers than is the rule in most hospitals." A year later, they could thank the city council for underwriting

⁴⁶ *AR for 1895*, p. 73; *AR for 1896*, p. 60; *AR for 1906*, p. 244–245. Rules for interns in this period indicate the difficulty in practice of distinguishing between the hospital and outward patients as well as the often moribund aspect of patients admitted. Philadelphia General Hospital, *Rules for Internes*, 1903, pp. 14, 16–17.

⁴⁷ *AR for 1907*, p. 7; *AR for 1900*, p. 12; *AR for 1908*, p. 81; Middleton, 1940.

⁴⁸ *AR for 1907*, p. 26.

the cost of 32 additional orderlies and "cleaners"; but still the shortage of nursing remained. Blockley had only 15 graduate nurses and 92 pupil nurses to care for nearly 1500 patients—a number that would demand 200 nurses in a properly staffed institution; as it was, "each head nurse has charge of a Department larger than the ordinary Hospital."⁴⁹ As we have seen, the title of Blockley's lay board had changed in a century from the Overseers of the Poor, to the Board of Guardians of the Poor to the Department of Charities and Corrections to the Department of Public Health and Charities. Realities could not be changed quite so neatly.

But statistics and administrative pleas for more generous support do not recreate the texture of that reality; no man knew the *fin de siècle* hospital better than Daniel Hughes, its chief resident physician. His letters, memoranda, and reports paint a picture of a grim and still intractable institution.

Discipline was perhaps his most difficult problem. Visiting physicians were often casual in their attendance and interns inattentive to clinical directives. House officers could be suspended for even chatting with a nurse on the wards. On one occasion a nurse had to be disciplined for striking a patient, on another an intern removed as "uncouth, boorish, and [unaware of] his shortcomings."⁵⁰ But Blockley's patients remained his most difficult disciplinary problem. Male venereal patients were, for example, a particularly truculent lot; they made trouble in the yards if let out for exercise and spent their evenings lounging and smoking in the bathrooms and water closets. And he could no longer use the threat of showers or cells; regulations did not allow even the chief resident to dismiss patients for disciplinary reasons.

Hughes's fundamental problem was, of course, the nature of Blockley's patient population, shaped by the unwillingness of most Philadelphians to enter unless forced by circumstance, and the parallel, if paradoxical, difficulty of finding a responsible home for patients ready to be discharged. Blockley served as the working man or woman's last resort; it was hardly surprising that so many should have been in extremis when admitted. As, for example, Margaret Ashley, black, nineteen, single, domestic, who arrived in 1898:

⁴⁹ AR for 1905, p. 329; AR for 1906, pp. 271, 280.

⁵⁰ Hughes to Alfred Moore, June 20, 1896, and Hughes to William Lambert, Dec. 2, 1896, chief resident's letterbook.

in a state of collapse, with a history of having been in labor for past three days. The foetus was dead, the umbilical cord protruding from the vagina from which came a fetid discharge. Doctor Peck, Visiting Obstetrician, had the patient placed under ether and opened the abdomen as the only means of delivering the child. It was found that the uterus had ruptured and the child had dropped into the abdominal cavity. The patient died before the operation was completed.

It was only to be expected, Hughes noted, that Blockley should report a death rate of 13 percent.⁵¹

Overcrowding was another chronic dilemma, a consequence of the enormous numbers who were Blockley's natural constituency. Such overcrowding, Hughes warned his residents in 1902,

necessitates my calling your attention to the matter of discharging all patients who are capable of being treated by a district physician providing they have a home to go to when discharged.

Kindly examine each of your patients with this object in view. Patients should not be required to sleep upon the floor at this season of the year; a time when the census of the hospital should be greatly reduced.

Eighty-nine patients had slept on the floor the previous night. The problem, of course, lay in the continued presence of patients who no longer needed attention, but could not be discharged because they were unable to care for themselves, "and if we send them away when they are unfit to care for themselves we open the way for adverse criticism." Many of those legitimately occupying beds were old and chronically ill, sufficiently ill to need some care but not so ill as to require active medical treatment:

This group of patients crowd the hospital wards and interfere with the satisfactory treatment of those requiring more active medication. If space could be found for the establishment of special wards for these elderly and somewhat helpless patients, it would be of great advantage to the aged themselves, while giving a needed relief to the medical and surgical wards.

And the outwards remained an inappropriate place to treat anyone, filthy, overrun with vermin, and ill-suited to maintaining the shaky

⁵¹ Hughes to S.H. Ashbridge, [1898], chief resident's letterbook, p. 461; *AR for 1899*, pp. 52-53.

health of their feeble inhabitants. Chronic wards tended inevitably to be ignored and sink into a custodial lethargy; when special tuberculosis wards were established at the end of the century, Hughes soon found that physicians were neglecting to make regular rounds among the consumptives.⁵²

Hughes's picture, of course, is that of a harried administrator seeking to subdue a difficult reality. Sherman Gilpin, his assistant resident physician for almost three years, kept a diary that illustrates even more immediately both the professional attractions and the dismaying realities that Blockley meant for an ambitious young physician. "Blockley is an unhealthy, miserable place to live," Gilpin confessed, "but it is very healthy for growth in medical knowledge." Despite a crushing burden of routine work—he might admit more than 30 patients on busy days—Gilpin attended postmortems and tried to perfect his German. Politics and petty discipline made a difficult job even more frustrating. One Sunday he planned to attend church but couldn't because he was unable to find the chief resident to get permission. "This being a slave I don't like." Even worse was the continued authority of political appointees, especially the superintendent. "If we had a man for Supt. and not a gruff, ignorant hypocrit [sic] of politician we might enjoy life a little even in Blockley." All the house staff ("medicals") detested the superintendent, Gilpin elaborated on another occasion: "He is a politician, an ex-councilman, and sail-maker. He is everything but what a Dr. wants him to be. He is like the common run of Politicians, lazy, officious, small in brains, who cares for himself & his money. He has no use for medical science and hasn't the brains to appreciate it. We want a medical Supt." (Gilpin, 1899–1901). Even more dismaying was his enforced contact with a class of patients who seemed so different from himself. "So many destitute cases," he described one day's work, "lousy and dirty, just sick enough to need hospital care." It was good, he complained wearily one Sunday, "going to church and realizing all the world are not paupers." Another evening, spent with a lady friend, meant an evening lost to study; but he reassured himself that "I must meet a few people at least out of Blockley in order to round off the

⁵² Hughes to the Resident Staff, July 21, 1902, chief resident's memorandum book; Hughes to J. Musser, February 9, 1898, chief resident's letterbook; *AR for 1899*, p. 59; Hughes to Resident Staff, May 7, 1903, memorandum book.

rough edges acquired by my contact with paupers." The gap that separated doctors and patients in the prebellum almshouse hardly narrowed in the second half of the century.

By 1910, the year of the Flexner Report and its call for a closer integration of hospital, medical science, and medical education, the Philadelphia General had become in some ways a hospital like any of its large, metropolitan, voluntary sisters. Indeed, it was far larger than most and boasted an enviable reputation as a place to teach and study clinical medicine. Its 13,000 admissions demanded the attention of 73 visiting staff members—10 surgeons, 12 physicians, 8 each of obstetricians and neurologists. A majority held teaching positions in the city's medical schools (the largest number at the University of Pennsylvania). Fifty of the 73 lived in the fashionable square bounded by Broad and Twenty-second Streets on the east and west, Market on the north, and Pine on the south. The hospital also boasted a house staff of 27 interns directed by the chief resident, an assistant chief resident, and a resident pathologist.⁵³ Blockley had become an integrated part of the twentieth-century medical world, articulated into both its intellectual and social structure.

On the other hand, as we have emphasized, it was still an almshouse. The hospital's death rate remained at 12 percent, and a large proportion of its patients were chronically ill. The average Blockley stay was 35 days in 1910, and 19 at Pennsylvania Hospital. The more things had changed, that is, the more they had remained the same. Blockley was still the residuary legatee for those cases desired least by Philadelphia's voluntary hospitals. And Blockley Hospital was still physically part of the almshouse complex—one known and feared by Philadelphia's working people. It was not until 1920 that the city opened a physically separate "Home for the Indigent," not until the years between 1919 and 1926 that the "insane hospital" was moved to a separate location in the then still-rural northeastern part of the sprawling city. Several more generations of interns and residents had still to experience the oversight of political appointees.

The city's social problems were not as amenable to a seeming technical solution—or even redefinition—as its medical ones. The chasm in social value between the public and the private sector remained. Class and social location still remained the primary deter-

⁵³ *AR for 1910*, pp. 121–127.

minant in deciding who would occupy Philadelphia's municipal hospital beds; and the problem of age, race, and chronic disease loomed if anything more prominently as the twentieth century progressed. With the retreat of the classic infectious diseases, the place of such problems only increased. For several years after the city of Philadelphia officially closed Philadelphia General Hospital in 1977, several hundred aged chronic patients remained in its depressing wards; the city had not yet remodeled a chronic disease hospital for them. These were patients that not even the promise of third-party payment could make palatable to other city hospitals and nursing homes. They were a fitting legacy for Blockley.

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