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**‘She supposes herself cured’: Almshouse Women and Venereal
Disease in Late Eighteenth and Early Nineteenth Century
Philadelphia.**

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Submitted in fulfilment of the requirements for the degree Doctor of Philosophy

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Abstract

This dissertation will explore the lives, experiences and medical histories of diseased almshouse women living in late eighteenth and early nineteenth century Philadelphia. During this period Philadelphia matured from being a relatively small colonial city into a major manufacturing metropolis. Venereal disease was omnipresent in America's major port city, and diseased residents were surrounded by a thriving medical marketplace.

Historians have identified the "who and why" of prostitution, however the scope of the prostitute experience has yet to be fully explored. This dissertation will address a considerable and important gap in the historiography of prostitutes' lives as it actually affected women. Venereal disease was an ever present threat for women engaging in prostitution, however casual, and historians have yet to illuminate the narrower aspects of the already shadowy lives of such women. Whether intentionally or by omission, historians have often denied agency to prostitutes and the diseased women associated with them, the effect of which has drained this group of sometimes assertive women of any individuality. While some women lived in circumstances and carried out activities that came to the attention of the courts, others lived more understated lives. A large proportion of the women in this study led the lives of "ordinary" women, and prostitution per se was not the only focal point of their existence. For many almshouse women their only unifying variables were disease, time and place. While prostitutes were often victims of economic adversity, they made a choice to engage in prostitution in the face of hardship and sickness.

The overall aim is to consider the diseased female patient's perspective, in an effort to illuminate how she confronted venereal infection within the context of the medical marketplace. This includes the actions she took, and how she negotiated with those in positions of authority, whose aim was sometimes -although not always- to curtail her activities. As many diseased women became more acquainted with the poor relief system of medical welfare, they were able to manipulate the lack of coherent strategy "from above", which left room for assertive behaviour "from below".

Diseased women did not always use the almshouse as a last resort-institution as historians often have us believe. Many selected the infirmary wing as opposed to other outlets of healthcare in Philadelphia, a city that was often labelled the crucible of medicine. There is also an oft-believed notion that prostitutes and lower class women suffering from venereal disease were habitually saturated with mercury “punitive-style” as treatment for their condition. This argument does not hold for those women who were cared for in the venereal ward of the almshouse’s infirmary wing. Broadly speaking, almshouse doctors did not sanction drastic depletion and the use of mercury compounds unless deemed absolutely necessary. Many almshouse doctors adopted a different therapeutic approach as compared with that of Benjamin Rush and his followers who dominated therapy at the Pennsylvania Hospital, a voluntary institution mostly closed off to venereal women. Such medical differences reflected wider transformations in ideas of disease causation, therapeutic approaches, medical education as well as doctor-patient relationships.

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Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, that this thesis is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature

Jacqueline Cahif

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Finally, I truly enjoyed attempting to give a voice to the many women who were the subjects of this study. They led precarious and difficult lives, often under the direst and most painful of circumstances. They deserve to be heard.

Abbreviations

APS: American Philosophical Society.

HSP: Historical Society of Philadelphia.

LCP: Library Company of Philadelphia.

M.M: Managers' Minutes.

PCA: Philadelphia City Archives.

PHA: Pennsylvania Hospital Archives and Historic Library, Philadelphia.

PPL: Pennsylvania Public Ledger.

P.M: Almshouse Physicians' Minutes.

Penn. M.M: Pennsylvania Hospital Managers' Minutes.

RCSPG: Royal College of Surgeons and Physicians, Glasgow.

Short Titles

Dockets: Daily Occurrence Dockets.

Register: Prostitutes' Register.

Vagrancy: Vagrancy Dockets.

Preface

In June of 1800, Rachel Ward left the Philadelphia Almshouse for the last time. Documented by the almshouse steward John Cummings as ‘one of our polishing room¹ gang’ and a ‘frequent...infamous venereal customer’, Rachel had sought almshouse treatment on numerous occasions throughout the 1790s. Having been clothed and treated, Rachel escaped the almshouse on five occasions that we know of, usually by ‘scaling and jumping the fence’. On one occasion, she ‘ran off half cured’ only to return a month later, much to the irritation of Cummings who labelled her as a ‘hussy [who] returns at pleasure’. This time he noted with evident disbelief ‘she says she has the gravel’. Rachel did not always elope by herself, and at a later date she absconded with fellow inmate Catherine Hayes, and the two women ‘ran [off] in the night’. Rachel was infected with venereal disease, and even from her earliest admission the infection had damaged her eyes so badly that she was ‘almost blind’. She was also committed to Walnut Street Jail for one month ‘after been caught in the house for fornicating’. This was not her first stint in the workhouse, having previously been incarcerated for being ‘idle, dissolute and disorderly’ under the Vagrancy Act.² There is no further record of Rachel after her spell of imprisonment in 1800.

¹ The almshouse steward frequently referred to the venereal ward as the polishing room. The managers for the most part used the term ‘venereal ward’, as did the physicians. After the early years of the nineteenth century diseased women also took up beds in the medical and surgical wards.

² Rachel Ward (also known as Rachel Howard), 7 Oct. 1789, 14 Dec. 1789, Mar. 1790, 6 Aug. 1794, Mar. 1796, Nov. 1797, Dec. 1797, June 1798, May 1799, 27 May 1800, 27 June 1800, Daily Occurrence Dockets, Guardians of the Poor, Philadelphia City Archives, hereafter cited as Dockets and PCA.; 18 Aug. 1790, Vagrancy Dockets, PCA. Hereafter cited as Vagrancy.

Introduction

Poverty, Prostitution, Venereal Disease and the Philadelphia Almshouse

When Benjamin Rush passed through the convalescent ward at Philadelphia's Bush Hill hospital for yellow fever victims he observed, 'there has been a sudden revival in the venereal appetite'.³ Apparently there had been a remarkable increase in 'the passion of the sexes' in the wake of the exceptionally brutal 1793 yellow fever epidemic. Few Philadelphia residents came off lightly, and of those who stayed in the city and had survived, most witnessed traumatic scenes of death and despair that had swept over the city. Perhaps life was too short for caution then. Hospital admission records testify to the omnipresence of venereal disease in early national Philadelphia. From the late 1780s Philadelphia paupers seeking venereal medical attention increased significantly. Every week the doors of the Philadelphia Almshouse and Pennsylvania Hospital were opened by the gatekeepers to let a constant stream of venereal sufferers into their wards. By 1798 the numbers of venereal patients entering the almshouse infirmary had swollen to the extent that 'it has become absolutely necessary to erect a new Building for the accommodation of venereal patients'.⁴

The burgeoning numbers of venereal disease victims was not solely the consequence of sexual overkill in response to recurring fever epidemics. Other factors were at play. Prostitution flourished in Philadelphia, which was home to America's principal port, and together with increasing numbers of transients and immigrants, these factors worked to facilitate the spread of disease. Recent research has uncovered a rise in sexual promiscuity in late eighteenth century Philadelphia, with more people engaging in casual and non-marital sex. Numerous literary sources appeared assaulting the sexual non-conformity of Philadelphians, particularly 'increased assertions in female autonomy'.⁵ In such an atmosphere, venereal disease appeared rampant beside diseases such as yellow fever, which hit Philadelphia particularly hard

³ John Harvey Powell, *Bring out your Dead* (Philadelphia: University of Pennsylvania Press, 1949), 252.

⁴ November 27 1783, May 15 1798. Guardians of the Poor, Philadelphia Almshouse Managers' Minutes, Philadelphia City Archives, Hereafter cited as M.M. and PCA.

⁵ Clare E. Lyons, *Sex Among the Rabble: An Intimate History of Gender and Power in the Age of Revolution, 1730-1830* (Chapel Hill: North Carolina University Press, 2006), 187-8, 309; Richard Godbeer, *Sexual Revolution in Early America* (Baltimore: John Hopkins University Press, 2002).

in the 1790s. Yet, as Susan Klepp remarks, although the death rates from yellow fever were astounding, the disease itself was just one of several epidemiological crises, certainly as measured by today's standards.⁶ The available evidence from hospital records indicates just how dominant venereal infection was as a single disease (and these are just the reported incidents), indicating in early Philadelphia it was indeed endemic.

Philadelphia was a divided city. Area historian Emma Lapsansky notes that if a stranger disembarked at this port from the late eighteenth century, they would find a city 'boastful of its modernity'. He would also find a 'wide choice of daily newspapers, a circus, several theatres and hospitals, a scholarly society, a medical school, art school and a city-wide water supply'.⁷ Philadelphia was indeed a 'world of technology and wealth [and] of gentlemen'. Yet the city had a dark side typical to urban expansion, with chronic impoverishment, disease and vice rife. Thus the same observer would also note the 'servants, slaves [and] poverty'.⁸ Historians have long recognised that frequent impoverishment characterised the lives of Philadelphia's lower sort, despite a general prosperity in the sprawling metropolis of America's premier city with a booming port that thrived on a rich maritime economy.⁹ Moreover, as the nation's capital Philadelphia hosted foreign ambassadors and America's most distinguished politicians, while also welcoming migrants from Europe, the Caribbean and elsewhere in the United States.

In such an atmosphere the better sorts believed the poor were becoming more visible and more vocal.¹⁰ Amongst this group of the city's underbelly who were often

⁶ Susan E. Klepp, 'How Many Precious Souls are Fled?: The Magnitude of the 1793 Yellow Fever Epidemic', in J. Worth Estes and Billy G. Smith (eds.), *Melancholy Sense of Devastation: The Public Response to the 1793 Yellow Fever Epidemic* (Philadelphia: Science History Publications, 1997). 171.

⁷ Emma J. Lapsansky, *Neighbourhoods in Transition: William Penn's Dream and Urban Reality* (New York: Garland Press, 1994), xv.

⁸ Ibid. 3.

⁹ Billy G. Smith, *Life in Early Philadelphia: Documents from the Revolutionary and Early National Periods* (Philadelphia: Pennsylvania State University Press, 1995), 3-5. Philadelphia was America's principal port city throughout the late eighteenth century. New York developed as an international port city slightly later than Philadelphia, and as such, prostitution did not develop and operate to the same extent until a later period. Timothy Gilfoyle, *City of Eros: New York City, Prostitution, and the Commercialization of Sex, 1790-1920* (New York: Norton, 1992).

¹⁰ According to Gary Nash, 'social thinkers blamed the poor for their plight [for] cultivating dependency and encouraging sloth'. While this way of thinking is commonly linked to a later period in the nineteenth century, Nash claims this 'change in attitude came earlier in seaport cities'. Gary Nash,

condemned by members of the respectable classes in need of control were the city's prostitutes. Yet there are two prevailing discourses portraying prostitutes' place during this period. On the one hand, prostitutes were increasingly marginalized in the America's New Republic. Women of all social classes were characterized by their productivity, that is, either their labour or their fertility.¹¹ By developing an idealized image of the 'Republican Mother', middling and upper class men and women ensured there was no place for prostitutes. Not only did they fail to contribute to society in a positive way, but their apparent lack of virtue made them dangerous to the moral fibre of the republic itself.¹² On the other hand, the concept of Republican Womanhood had little meaning to most women of the lower sort, many of whom barely earned enough to scrape by. Thus, there is a conflicting historical discourse that firmly places prostitutes and prostitution as an accepted or at least tolerated part of the city's terrain.

Prostitutes were first and foremost wage-earners, and like other workers their labour was a commodity to be bartered and sold in the open market. By the latter years of the eighteenth century, women were entering the urban workforce en-masse, as a distinct class of paid workers emerged in America's largest cities.¹³ According to Karin Wulf, Philadelphia was a 'plebian city' with the minority rich 'surrounded by armies of servants and dressmakers, carters and dockhands [and] shoemakers' apprentices'.¹⁴ Occupational options for women were limited, exacerbated by poor working conditions and marginal pay. Employment prospects were also constrained by social convention to jobs as teachers, milliners, seamstresses, hucksters, maids, servants and laundrywomen. Carole Shammas has shown that households during the late eighteenth century were headed by women in up to 20 percent of Philadelphia

'Poverty and Politics in Early American History', in Billy G. Smith (ed.) *Down and Out in Early America* (Philadelphia: Pennsylvania University Press, 2004), 16, 19.

¹¹ Susan Klepp, 'Revolutionary Bodies: Women and the Fertility Transition in the Mid-Atlantic Region, 1760-1820', *Journal of American History*, Vol. 85, No. 3 (1998).

¹² Linda Kerber, *Women of the Republic: Intellect and Ideology in Revolutionary America* (Chapel Hill, University of North Carolina Press, 1980). On the historical constructs of Republican Womanhood see Linda Kerber, 'The Republican Mother: Women and the Enlightenment: an American Perspective', *American Quarterly*, Vol. 28, No. 2 (1976), 187-205; Mary Beth Norton, *Liberty's Daughters: the Revolutionary Experience of American Women, 1750-1800* (Boston: Little Brown, 1980); Jan Lewis, 'The Republican Wife: Virtue and Seduction in the Early Republic', *William and Mary Quarterly*, 3rd Series, No. 44 (1987), 689-721.

¹³ Smith, *Life in Early Philadelphia*, 10.

¹⁴ Karin Wulf, *Not All Wives: Women of Colonial Philadelphia* (Philadelphia: University of Pennsylvania Press, 2005), 131.

homes.¹⁵ Even if married, the majority of lower class women had to join their single counterparts in employment, and competition could be fierce. Thus Jeanne Boydston suggests that the working women of the early republic were ‘an aggressive and ostensibly and autonomous presence’ in the urban setting.¹⁶ Such was women’s work in early national Philadelphia.

Two events severely impacted lower class women’s economy during the late eighteenth century: the American Revolution and recurring yellow fever epidemics, both of which resulted in high degrees of widowhood. Consequently more women searched for work, and an ever increasing number turned to public assistance to cope with the burdens of impoverishment. Yet transformations in welfare practices brought about radical changes, and for poor women this meant amendments in the ways they dealt with poverty. Women’s needs became inferior to their men’s and welfare officials now viewed poor men as being the source of women’s poverty, thus they shifted their attentions to male rehabilitation, making significant cutbacks in female public assistance.¹⁷ Institutional care became the predominant source of welfare by the closing years of the century, and together with limited occupational opportunities and low pay, such conditions often encouraged prostitution.¹⁸

Prostitution was not a certified crime in early Philadelphia, yet the laws were confusing, inconsistent, and often contradictory. Occasionally prostitutes found themselves in trouble with the law, although not for engaging in prostitution per se. Marcia Carlisle has shown that streetwalkers were arrested by the city watch as vagrants, mostly for drunk and disorderly behaviour. As such, prostitutes were able to move ‘openly and freely’ in the city’s landscape.¹⁹ Claire Lyons confirms that during the 1790s there were fewer than two arrests per month for prostitution, a strikingly

¹⁵ Carole Shammas, ‘The Female Social Structure of Philadelphia in 1775’, *Pennsylvania Magazine of History and Biography*, Vol. 107, No.1 (1983), 72.

¹⁶ Jeanne Boydston, ‘The Woman Who Wasn’t There, Women’s Market Labour and the Transition to Capitalism in the United States’, *Journal of the Early Republic*, Vol. 16, No.2, (1996), 194.

¹⁷ Karin Wulf, ‘Gender and the Political Economy of Poor Relief in Colonial Philadelphia’, in Billy Smith (ed.), *Down and Out in Early America* (Philadelphia: Pennsylvania University Press, 2004), 164-6.

¹⁸ Prostitution was not always simply motivated by poverty, and the issue of female agency in relation to prostitution is a topic historians have hotly debated. Christine Stansell, *City of Women: Sex and Class in New York, 1789-1860* (Urbana: University of Illinois Press, 1987), 171.

¹⁹ Marcia Carlisle, ‘Disorderly City, Disorderly Women: Prostitution in Ante-Bellum Philadelphia’, *Pennsylvania Magazine of History and Biography*, Vol. 110, No. 1 (1986), 549.

small proportion given the numbers of prostitutes who ‘flooded’ the streets.²⁰ Brothel raids were sporadic and minimal, and unless an establishment came to the attention of local watchman for being rowdy, prostitutes were generally tolerated.²¹ Prostitutes’ arrests should thus be seen within the context of the larger riotous street culture that existed in Philadelphia. Moreover, it has been suggested that women who engaged in prostitution were not isolated by their communities. Marilyn Wood Hill has shown that New York prostitutes were often fully integrated with their neighbours, thus not ostracized by their communities as they would be at a later date when prostitution became the ‘social evil’.²²

Furthermore, as a consequence of shifting patterns in sexual behaviour from the middle of the eighteenth century, there were significant changes in family relationships. A decline in patriarchal authority produced new expectations of personal autonomy and greater social mobility. The younger generation began rejecting parental control and increasingly engaged in illicit sexual activity. As such, Philadelphia developed an ‘expansive and permissive sexual culture [as] members of all classes and both races frequented taverns [and] bawdyhouses for sexual behaviour’.²³ By the 1820s, more concentrated efforts were made by the middle classes to ‘reform’ prostitutes.²⁴ Just like the poor would be blamed for their desperate condition, diseased women came under increasing culpability and surveillance by respectable society. Lyons adds that ‘the period 1800-1830 saw increasing conflict and resistance as elite and middle class Philadelphians responded to the threats they perceived in expansive sexual practices and the permissiveness of the city’s sexual culture’.²⁵ For the most part however, prostitutes were left alone by the city watch and

²⁰ Lyons, *Sex Among the Rabble*, 193.

²¹ Brothels were not targeted in Philadelphia as illicit venues until later in the nineteenth century, well behind Boston where attacks on brothels were frequent earlier in the century. See Barbara Hobson, *Uneasy Virtue: the Politics of Prostitution and the American Reform Tradition* (Illinois: University of Chicago Press, 1987). Moreover, known prostitutes used the courts in the same way as Philadelphia’s more “respectable” citizens to make complaints similar to those that were made against them. Carlisle, ‘Disorderly Women, Disorderly City’, 549-68.

²² Marilyn Wood Hill, *Their Sisters Keepers: Prostitution in New York City, 1830-1870* (Berkley: University of California Press, 1993), 3, 17.

²³ Lyons, *Sex Among the Rabble*, 193.

²⁴ By the second third of the nineteenth century Bruce Dorsey points out that ‘middle class Protestants in northern cities embraced a new definition of benevolence that quickly superseded eighteenth century models of humanitarianism’. Bruce Dorsey, *Reforming Men and Women: Gender in the Antebellum City* (New York: Cornell University Press, 2003), 51.

²⁵ Lyons, *Sex Among the Rabble*, 309

although rudimentary measures of policing were in place, Philadelphia constables were selective and inconsistent.²⁶

These two discourses have informed the historiography. On the one hand there is an explanatory framework that prostitutes were tolerated and left alone to carry on their business. Yet an opposing interpretation suggests they were judged by city officials along with other groups perceived to be deviant, and accordingly kept off the streets.²⁷ Indeed, prostitutes were perceived by some members of the community as posing a threat. The Magdalen Society was established in 1800 as a receptacle for young prostitutes considered as ripe for reform, reflective of growing concern amongst the elite about the increase in prostitution and the apparently relaxed sexual code. Although such concerns did not materialise fully until a later period, there were nevertheless signs of anxiety over women's independence

It is not clear whether prostitutes were regarded as a threat to the health of the infant republic. Despite the burgeoning urban population, the social crises generated by industrial development and mass immigration did not spark the development of properly defined public health bodies until later in the nineteenth century. Philadelphia suffered greatly from endemic and epidemic disease, yet only sporadic temporary measures were put in place to deal with the problems associated with yellow fever and cholera epidemics. Jacqueline Miller and Martin Pernick have shown that the health measures implemented as a response to yellow fever outbreaks were more the consequence of state obligation than genuine concerns for public health.²⁸ Moreover, there were no institutions like the British Lock hospitals catering specifically to syphilis.

²⁶ According to Roger Lane, this was partly because of the constant stream of immigrants and transients who contributed their fair share to the riotous and disorderly nature of many of the city's districts. This was in turn exacerbated by the difficulties posed by attempting to police unrealistic political boundaries. Roger Lane, *Violent Death in the City: Suicide, Accident and Murder in Nineteenth Century Philadelphia* (Ohio State University Press, 1999), 7.

²⁷ Simon P. Newman, *Embodied History, The Lives of the Poor in Early Philadelphia* (Philadelphia: University of Pennsylvania Press, 2003), 20, 33.

²⁸ Martin S. Pernick, 'Politics, Parties and Pestilence: Epidemic Yellow Fever in Philadelphia and the Rise of the First Party System', Jacqueline C. Miller, 'Passion and Politics: The Multiple Meanings of Benjamin Rush's Treatment of Yellow Fever', both essays in J. Worth Estes and Billy G. Smith (eds.), *A Melancholy Sense of Devastation: The Public Response to the 1793 Yellow Fever Epidemic* (Philadelphia: Science History Publications, 1997).

There was certainly little evidence in the writings of the Philadelphia medical community that prostitutes were perceived to be a threat to the health of society. This time preceded an era when the spread of venereal disease came to the fore as a significant public health issue. Although contemporaries held an understanding of the basic communicable nature of the infection and were aware of its threat towards the health of others, there is little to suggest that prostitutes were held responsible by doctors as the agents of transmission. According to Christine Stansell, urban prostitution reached its maturity in American as a social and medical problem in the 1850s. This was to the extent that city fathers in New York commissioned medical investigations into the prevalence of the problem.²⁹ Subsequently, Dr. William Sanger published a social scientific study on the extent of prostitution and venereal disease in New York City, part of which was based on interviews with prostitutes incarcerated in the city's Blackwell Prison. The Guardians of the Poor in Philadelphia followed similar suit in the early 1860s, recording diseased women on a separate almshouse Prostitutes' Register. The questions asked of women were borrowed verbatim from Sanger, suggestive that prostitutes were under increased surveillance as transmitters of disease.³⁰ By the mid-nineteenth century then, the prostitute would be increasingly confined and isolated.³¹

The historiography of late eighteenth century Philadelphia points to the creation or expansion of institutions in order to contain and control those who were perceived to threaten the moral fabric of society. During the early national period Michael Meranze suggests there was a 'dramatic invention and dissemination of disciplinary techniques and locations throughout the city [and these] efforts shared techniques, practices and effects'.³² The realm of poor relief behind the walls of the city's almshouse became one such stage where new visions of surveillance were played out. During the later decades of the eighteenth century, public welfare administered through outdoor relief in the forms of small cash payments and fuel was supplanted by the expansion of

²⁹ Christine Stansell, *City of Women: Sex and Class in New York, 1789-1860* (Urbana: Illinois University Press, 1987), 171.

³⁰ William Sanger, *The History of Prostitution: Its Extent, Causes and Effects throughout the World* (Harper: New York, 1859); Guardians of the Poor, Philadelphia Almshouse Prostitutes' Register, c.1860-63, PCA.

³¹ Marcia Carlisle, 'Prostitutes and their Reformers in Nineteenth Century Philadelphia', Unpublished PhD Thesis (Rutgers, State University of New Jersey, 1982), 15

³² Michael Meranze, *Laboratories of Virtue: Punishment, Revolution and Authority in Philadelphia, 1760-1835* (Chapel Hill: University of North Carolina Press, 1996), 3-4.

institutional indoor relief. Consequently, Philadelphia's most needy residents increasingly found themselves confined behind the brick walls of the almshouse.³³ According to Simon Newman, the Philadelphia Almshouse functioned as a refuge for the correction and medical treatment of the lower sort.³⁴ Despite disagreements about the nature of almshouse confinement as will become apparent, historians accept that American almshouses functioned to a certain extent as rehabilitative instruments of social control and moral reform. This interpretation casts the almshouse as a receptacle for the indigent poor and unruly rabble where they could be removed from the streets and controlled. The almshouse indeed received a motley crew of inmates. According to institution historian Robert J. Hunter, in the eighteenth century, 'the first place in Philadelphia to which the poor and the sick, the unfortunate girl and the unemployed, the aged and the insane could go, was the Philadelphia Almshouse'.³⁵



Figure 1 William Birch, Alms House in Spruce Street, Philadelphia, 1799.

³³ For a detailed discussion on changes in poor relief administration see Wulf, *Not All Wives*, 153-79.

³⁴ Newman, *Embodied History*, 4, 20.

³⁵ Robert J. Hunter, 'The Origin of the Philadelphia General Hospital', *Pennsylvania Magazine of History and Biography*, Vol. 7 (1933), 39.

Moreover, the almshouse served an important medical function that would eventually surpass its role as an instrument of social control. David Rothman contends that almshouses became hospitals unintentionally as a result of their admission policies, because ‘the most difficult cases and the ones that the community had the least desire to accommodate were often the diseased [and] the sick made up a sizeable proportion of the almshouse population’. Thus by the end of the colonial era, the almshouse had ‘became a collection point for illness’.³⁶ This is confirmed by Billy Smith who suggests that ‘while ostensibly designed to serve the needs of the elderly, widowed, orphaned and infirm primarily’, those categories accounted for relatively few inmates by the turn-of-the-century.³⁷ The Philadelphia Almshouse held an important role as a key provider of healthcare in the city’s medical marketplace. Its importance in this role cannot be overlooked according to ex-almshouse physician David Hayes Agnew for both ‘the medical profession and the community’.³⁸ During much of the eighteenth century the evidence suggests that the managers envisioned the almshouse to be little more than a welfare institution for temporary poverty. Yet, according to ex almshouse physician Samuel Jackson writing in 1827,

...the Alms-house Infirmary is one of the best clinical schools in this country, from the numbers of patients brought into its medical and surgical wards, and the immense variety of diseases...constantly to be found behind its walls. The numbers of annual admissions into the Alms-house average above four thousand and of those into the Infirmary over three thousand.³⁹

The almshouse infirmary played a significant role then in the lives of many poor Philadelphia women suffering from venereal disease, and like Rachel Ward they would often exploit its resources as far as possible.

Historiography

Prostitution and the Prostitute

³⁶ David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown, 1971), 45.

³⁷ Billy G. Smith, *The Lower Sort, Philadelphia’s Laboring People, 1750-1800* (New York: Cornell University Press, 1990), 168.

³⁸ David Hayes Agnew, ‘Medical History of the Philadelphia Almshouse’, in David Hayes Agnew and Alfred Stille (eds.), *History and Reminiscences of the Philadelphia Almshouse* (Philadelphia: 1890), 55.

³⁹ Samuel Jackson M.D., ‘Clinical Reports of Cases Treated in the Infirmary of the Almshouse of the City and County of Philadelphia’, *The American Journal of Medical Sciences*, Vol. 1 (1827), 85.

The literature on the history of prostitution is vast, as are intellectual histories of venereal disease. One of the ground breaking works instigating future studies is Judith Walkowitz's *Prostitution and Victorian Society*. Walkowitz reaches into the world of prostitution by analysing the efforts of reformers and the state to control and contain prostitutes as a result of the Contagious Diseases Acts. These parliamentary statutes introduced measures making medical inspection compulsory for prostitutes in English port and garrison towns.⁴⁰ Overall this work is a study of social attitudes. Since the 1980s there has been a proliferation of studies on the history of prostitution in America.⁴¹ However, attention has been devoted -on both sides of the Atlantic- to analysing the ideology of middle class philanthropic reformers, social commentators and journalists.⁴² Writing about nineteenth-century New York, Christine Stansell observes that 'prostitutes flitted wraithlike across the pages of urban social commentary'.⁴³ It naturally follows that many studies have been organised around paradigms based on reformist viewpoints and gender theories. Barbara Hobson follows this tradition in *Uneasy Virtue: The Politics of Prostitution and the American Reform Tradition*. From a study of court and penitentiary records, Hobson accounts for the change in attitudes of reformers and the law contending that officials increasingly focused on the female prostitute in the nineteenth century as a source of disorder.⁴⁴ The Philadelphia historiography is similar, and most historians have relied on deconstructing the attitudes apparent in the sources generated by the policymakers and reformers of the Magdalen Society.⁴⁵ While informative, such evidence is

⁴⁰ Judith Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1980).

⁴¹ Jacqueline Barnhart, *The Fair But Frail: Prostitution in San Francisco, 1849-1900* (Reno, University of Nevada Press, 1986); Anne M. Butler, *Daughters of Joy, Sisters of Misery: Prostitutes in the American West, 1865-1890* (Urbana: University of Illinois Press, 1985); Timothy Gilfoyle, *City of Eros, New York City, Prostitution and the Commercialisation of Sex* (New York: W.W. Norton & Co., 1994); Marilyn Wood Hill, *Their Sisters Keepers: Prostitution in New York City, 1830-1870* (Berkeley: University of California Press, 1993).

⁴² Joel Best, *Controlling Vice, Regulating Brothel Prostitution in St. Paul, 1865-1883*, (Columbus: Ohio State University Press, 1998); Tony Henderson, *Disorderly Women in Eighteenth Century London: Prostitution and Control in the Metropolis, 1730-1830* (New York: Pearson Education Ltd, 1999); Mark Thomas Connolly, *The Response to Prostitution in the Progressive Era* (Chapel Hill, University of North Carolina Press, 1980); Barbara Hobson, *Uneasy Virtue: The Politics of Prostitution and the American Reform Tradition* (Chicago: University of Chicago Press, 1987); Thomas C. Mackey, *Red Lights Out, A legal History of Prostitution and Vice Districts, 1870-1987* (New York: Garland, 1987).

⁴³ Stansell. *City of Women*, 171.

⁴⁴ Hobson, *Uneasy Virtue*, 48.

⁴⁵ Marcia Carlisle, 'Prostitutes and Their Reformers'; Rodney Hessinger, *Seduced, Abandoned and Reborn, Visions of Youth in Middle Class America, 1780-1850* (Philadelphia: University of Pennsylvania Press, 2005); Lyons, *Sex Among the Rabble*, Chapter 7; Steven Ruggles, 'Fallen Women:

unrepresentative of the prostitute population. The Magdalen Asylum was a small world closed off to most prostitutes, and those who entered were predominantly young women. This was highlighted by Steven Ruggles, who illustrated the changes and continuities in the policies of the asylum managers, thus being more of an institutional history.⁴⁶

Some historians have leaned towards theoretical and post-modernist arguments by deconstructing the social meanings and representations of prostitution, known to some as the 'linguistic turn'. Evidence is taken from the narratives of social commentators and journalists reporting and warning on sexuality and sexual danger, morality tales generated in magazines, and sensationalist accounts in newspapers, crime pamphlets and poems.⁴⁷ Lyons assesses gender relations and sexual behaviours in early national Philadelphia in *Sex among the Rabble*.⁴⁸ She contends that, through a cultural reconstruction of sex outside wedlock, 'all non-martial sex became prostitution'.⁴⁹ This evidence is based upon the range of sexual meanings and images illustrated in the popular print culture. However, by relying on the representations of prostitutes by contemporaries, historians have not treated prostitutes as individuals living under varied circumstances. This methodology is something some historians view with suspicion given the tendency to merge fact with fiction. We are too often easily influenced by representations of prostitution as illustrated in popular literature and print. Timothy Gilfoyle laments that there is consequently little separation of such 'facts' from their production and historians of prostitution are often 'doomed by the subjectivity of their sources', with such interpretations become located 'in layers of myth and fabrication' and the precise history is therefore lost.⁵⁰ Many contemporary narratives depicted the prostitute as either naively abandoned to male seduction and consequently forced into prostitution, or alternatively motivated by utter impoverishment. Yet routes into sex commerce differed from one woman to the next,

The Inmates of the Magdalen Society Asylum of Philadelphia 1836-1908', *Journal of Social History* Vol. 16, No. 4 (1983); 65-82.

⁴⁶ Ruggles, 'Fallen Women', 65-82.

⁴⁷ Linda Mahood, *The Magdalens: Prostitution in the Nineteenth Century* (London: Routledge, 1990); Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (London: Virago, 1992).

⁴⁸ Lyons, *Sex Among the Rabble*, 313-5.

⁴⁹ Ibid, 312.

⁵⁰ Timothy Gilfoyle, 'Prostitutes in History: From Parables of Pornography to Metaphors of History', *American Historical Review*, Vol. 104, No.1 (1999), 117-49.

and often the decision to engage in prostitution was based on choice. Ruth Rosen reminds us that ‘the vast majority of women who practised prostitution were not dragged, drugged or clubbed into involuntary servitude’.⁵¹ Moreover, until the later nineteenth century women rather than men controlled prostitution in America, many of whom displayed ‘entrepreneurial attitudes’.⁵² For many though, the element of choice was constrained by several factors, such as gender, race and financial considerations.

Although the above methodologies undoubtedly reveal much about the history of prostitution, they nevertheless tend to depict prostitutes as a homogenous group. Portraying prostitutes as sharing a collective experience tends to drain them of individuality, ultimately depicting them as abstract metaphors rather than women living varied existences under diverse circumstances. Actual experience has been neglected and the concrete realities of prostitute’s lives have too often been given scant attention. Sociologist Teela Sanders recently observed that ‘historically sex workers have been portrayed variously as purveyors of disease, a social evil, public nuisance...and as victims needing rescued from their abject state’.⁵³ Here lies the problem. While it is important to recognise how civic authorities and more prosperous citizens judged and dealt with prostitution, such approaches tell us more about middle class morality and ideals than they do about prostitutes themselves. There are, however, some notable exceptions that address the actual experiences of prostitutes, rather than the efforts of those “from above” to curtail their activities. Rather than relying on sensationalist accounts in newspapers and court records, these authors have opened up the economic, cultural and social world of the prostitute by getting down to the ‘nitty gritty’ through an examination of the data from poor law, hospital, penitentiary records and personal letters of correspondence.⁵⁴

⁵¹ Ruth Rosen, *The Lost Sisterhood: Prostitution in America, 1900-1918* (Baltimore: John Hopkins University Press, 1982); 137. Also see Hill, *Their Sisters Keepers*, 5, 106.

⁵² Carlisle, *Disorderly City*, 549.

⁵³ Teela Sanders, *Prostitution: Sex Work, Policy and Politics* (London: Sage, 2009), 33.

⁵⁴ The best histories that consider the scope and circumstances of prostitutes lives are Laurie Bernstein, *Sonia’s Daughters: Prostitutes and their Regulation in Imperial Russia* (Berkeley: University of California Press, 1995); Alan Corbin, *Women For Hire: Prostitution and Sexuality in France After 1850* (London: Harvard University Press, 1990); Marilyn Wood Hill, *Their Sisters Keepers: Prostitution in New York City, 1830-1870* (Berkeley: University of California Press, 1993); Frances Finnegan, *Poverty and Prostitution: A Study of Victorian Prostitutes in York* (Cambridge: Cambridge University Press, 1979).

Gilfoyle has therefore called for historians to ‘attend to the lives of prostitutes themselves’.⁵⁵ While historians of European prostitution have examined family background and marital status for instance, Gilfoyle suggests American researchers should do the same using a variety of archival materials including the ‘little exploited source of incarceration records’.⁵⁶ It is in these records he explains, that we find the ‘poorest and least protected prostitutes’.⁵⁷ In her study of elite prostitutes, Hill also contends that new research should ‘explore different aspects of prostitution, enlarging both the chronological and geographical perimeters of the topic’. Thus, a study on prostitutes who made their way to the Philadelphia Almshouse is needed. Writing in the early 1990s Thomas Surgue argued that,

...the poor have remained shadowy figures in American social history and histories from the bottom up, in vogue since the 1960s have generally left the very bottom out...even those histories of poor relief and welfare.⁵⁸

Many valuable contributions have since been made by historians investigating the nature of urban poverty, most notably led by Susan Klepp, Gary Nash and Billy Smith.⁵⁹ Therefore this dissertation will also attempt to add to these histories. A study of almshouse women provides a more enriched interpretation and understanding of prostitute and lower sort women’s experiences and the circumstances of their lives.

The Prostitute and Venereal Disease

The most surprising aspect in the historical scholarship on prostitution has been the tendency to skim over the health aspect of prostitutes’ lives, and historians who have sought to recover “experience” are particularly guilty of this. While there is an acknowledgement of the link between prostitution and venereal disease, both issues appear to be treated as mutually exclusive, and when venereal disease is mentioned, it

⁵⁵ Timothy Gilfoyle, ‘Prostitutes in the Archives, Problems and Possibilities of Documenting the History of Sexuality’, *American Archivist*, Vol. 57, No. 3 (1994), 518.

⁵⁶ Gilfoyle, ‘Prostitutes in the Archives’, 518.

⁵⁷ Ibid. Periods of intermittent regulation in Europe produced considerable data form registers of prostitutes compiled by police and law enforcement agencies. American prostitutes were less controlled thus depriving the historian of similar evidence.

⁵⁸ Thomas Surgue. ‘The Structures of Urban Poverty: The Reorganization of Space and Work in Three Period of American History’, in Michael B. Katz (ed.) *The Underclass Debate* (Princeton: Princeton University Press, 1993), 86.

⁵⁹ See the relevant chapters in Smith, *Down and Out*, (2004).

is done so minimally. Of course to a certain extent this gap in the literature is dictated by the paucity of sources. This is unfortunate, because in a day without widespread use of prophylactics, illness very often accompanied prostitution, and a prostitute habitually faced the danger posed by infected customers. Sexually transmitted diseases could be painful, debilitating and for the victim all-encompassing once the disease spread. Venereal infection was therefore very much a part of the prostitute's experience.

The issue of venereal disease and its association with prostitution has been given a nod by historians, yet only in relation to measures implemented "from above" to control its spread. We simply have not heard how the disease actually affected prostitutes, and as a consequence of a lack of research into this field, many unsupportive assumptions have been made. Much work has been done regarding the Lock hospitals, yet the historiography is somewhat disappointing with regards to how women were actually medically treated with the emphasis being firmly focused on the regulation of, and moral attitudes toward those who were housed in these institutions.⁶⁰ While many insightful and important studies have been carried out on the ways the poor were able to access public welfare -whether through outdoor or indoor relief- little work has been done on the poor's experience of illness and in particular, pauper medicine.

Historical representations of venereal disease as a 'secret malady' has also informed discussion, and as Linda E. Merians points out, authors have tended to 'honour the secrecy of the disease by treating it tangentially as imagery or as anecdote'.⁶¹ Bertrand Taithe recently argued that the history of venereal disease as a sub-genre for the history of medicine has become 'stale' in light of an emphasis on providing intellectual frameworks.⁶² One of the problems he explains lies in the 'ongoing tendency of scholars to persist with the theme of morality -whether tangentially or centrally- as a framework for analysis'. Taithe stresses the need for historians to find a

⁶⁰ The exception is Kevin Siena, *Venereal Disease, Hospitals and the Urban Poor* (New York: University of Rochester Press, 2004).

⁶¹ Linda E. Merians, *The Secret Malady: Venereal Disease in Eighteenth Century Britain and France* (Kentucky: University of Kentucky Press, 1996), 9.

⁶² Bertrand Taithe 'Morality is not a Curable Disease: Probing the History of Venereal Diseases, Morality and Prostitution', *Social History of Medicine*, Vol. 14, No. 2, (2001), 337-50.

way out of these constraints and proposes a sharp departure from the 'regulation-led narrative literature'.⁶³

Taithe particularly objects to Mary Spongberg's *Feminizing Venereal Disease*. The title of this monograph would naturally excite any historian of prostitutes and venereal disease. Spongberg promises a break from the class analysis characteristic of prostitution histories (Walkowitz and Stansell spring to mind) and offers the reader a fresh perspective on the British Contagious Diseases Acts. Using an older tradition of patriarchal oppression as a framework, she argues that the Acts were a culmination of male doctors' public health measures that utilized public policy as a method of social control, often over working women's sexuality. Like some of the abovementioned historiography, Spongberg covers old ground and presents the prostitute exactly how she was represented by those in positions of power.⁶⁴ Spongberg also has the tendency to present all prostitutes as innocent and in a victimized light. Again we lose sight of the real circumstances of the subject's lives. Significantly, it has been suggested that prostitutes did not see always themselves as victims. This is a point made by F.B. Smith in relation to the 'antis' such as Josephine Butler who challenged the Acts. One of Butler's arguments was that regulation measures implemented in English port and garrison towns brutalised prostitutes. Yet prostitutes actually used the Acts to their own advantages. Some women travelled from out of town to designated points of medical inspection, where they received free treatment for the itch (scabies), 'an affliction they feared more than gonorrhoea' or other venereal complaints. Smith argues that prostitutes generally left in better health with a heightened sense of esteem, and often, flaunting their certificates.⁶⁵ Prostitutes were portrayed by those who challenged the Acts in victimized terms using language such as 'poor harlots... ruined women...in bondage'.⁶⁶ This has encouraged historians of prostitution to portray women in the same terms. A similar theme was stressed by Stansell who claimed that women often made a rational choice to engage in prostitution. As she noted,

⁶³ Ibid, 344.

⁶⁴ Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth Century Medical Discourse* (New York: New York University Press, 1998).

⁶⁵ F.B. Smith, 'The Contagious Diseases Acts Reconsidered', *Social History of Medicine*, Vol. 2, No.3 (1990), 208-9.

⁶⁶ Ibid.

...we are still too influenced by the Victorians view of prostitution as utter degradation to accept easily any interpretation that stresses the opportunities commercial sex provided to women rather than the victimization it entailed.⁶⁷

Taithe urges historians to separate prostitution and venereal disease from the shackle of morality narratives using 'new intellectual tools'. He also suggests that 'one of the great gaps in the historiography is 'any attempt to understand how pox was dealt with and how people grappled with its...occurrence'.⁶⁸ Since Taithe's article one monograph has appeared that has expertly begun to fill this gap. Kevin Siena's *Venereal Disease, Hospitals and the Urban Poor* offers a fresh and insightful analysis on the experience of venereal disease encapsulated within the broader context of poverty, welfare and health. Siena departs from the morality and reforming impulses so characteristic of the historiography, and illustrates the forms of healthcare provision that were available to London's syphilitics, from the rich to the poor. This work is also notable for the emphasis placed upon the important medical role played by English workhouses.⁶⁹ Siena suggests that too few historians have teased out issues relating to health care from workhouse or poorhouse records.

American almshouse records have been mined by social historians who have produced important studies on the inmates of these institutions. However, issues relating to health and healing have been largely ignored. A wide range of ailments were represented in Philadelphia's almshouse, which indeed acted like a hospital by the close of the eighteenth century. By highlighting the more sinister side of such institutions as instruments of social control, there has been a tendency to treat the almshouse as a dispenser of charity first and foremost rather than as medical provider.⁷⁰ This is despite the fact that much of the qualitative evidence is drawn from lay administration records that often refer to the curative role of the institution, even though it was a receptacle for the chronic sick. That the almshouse steward continually noted his charges as 'cured' or 'somewhat mended' illustrates this point. Jonathan Andrews has pointed towards this aspect of the historiography in his study of therapeutics at Bethlem. Andrews challenges 'the usual depiction of Bethlem as an

⁶⁷ Stansell, *City of Women*, 191.

⁶⁸ Taithe, 'Morality is not a Curable Disease', 343-6.

⁶⁹ Siena, *Venereal Disease*, 136.

⁷⁰ For an exception in Europe see Jonathan Andrews, 'Hardly a Hospital but a Charity for Pauper Lunatics: Therapeutics at Bethlem, in Barry and Jones, (eds.) *Medicine and Charity Before the Welfare State* (London: Routledge, 1991), 63-81.

almshouse or detention centre rather than a centre of cure'. He argues that the asylum infirmary was dedicated to curing patients, also stressing that 'we must be careful not to underestimate the sympathetic spirit of the relief at Bethlem'.⁷¹ An illuminating study that adds significantly to the valuable work carried out by Tim Hitchcock on pauper experience is Alannah Tomkins account of urban impoverishment in eighteenth century English workhouses. Importantly, in *The Experience of Urban Poverty* Tomkins devotes a chapter to the forms of medical welfare available at workhouse infirmaries. She suggests that medicine provided to paupers was of a low standard noting that,

The presence of one relatively high status surgeon amongst overseers' payments should not obscure the fact that Blakely [a surgeon] embodied the most elite medical attendance paupers could expect...but his employment was not representative.⁷²

Patients at the Philadelphia Almshouse infirmary could not be in a more different position from those in Tomkins study. The almshouse was well-known as a site of prestigious clinical training amongst the American medical community. Tomkins study is highly insightful on the experience of urban poverty, and while she does investigate medical welfare at the infirmaries, this unfortunately stops short of examining actual medicine. While historians have recently attempted to address this gap, most tend to be institutional histories that refrain from attending to actual therapeutic practice.⁷³ Charles Rosenberg pointed out several decades ago that 'therapeutics has always been central to medical practice, but not to the practice of the professional historians'.⁷⁴

When therapeutics is accounted for, historians have often assumed that workhouse infirmary medicine reflected the retributive and disciplinary nature of such institutions. This interpretation is exacerbated by historians of prostitution who focus firmly on

⁷¹ Ibid., 67.

⁷² Tim Hitchcock, *Chronicling Poverty: The Voices and Strategies of the English Poor* (Houndmills: Macmillan Press, 1997); Alannah Tomkins, *The Experience of Urban Poverty, 1732-82: Parish, Charity and Credit* (Manchester: University of Manchester, 2006).

⁷³ See the collection of essays in Peter Grell, Andrew Cunningham and Robert Jutte (eds.) *Health Care and Poor Relief in 18th and 19th Century Europe* (Burlington: Ashgate, 2001); Jonathan Barry and Colin Jones, (eds.) *Medicine and Charity before the Welfare State* (London: Routledge, 1991).

⁷⁴ Charles Rosenberg, 'The Therapeutic Revolution: Medicine, meaning and social change in nineteenth century America', in Charles Rosenberg, *Explaining Epidemics and other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 9

regulation-led narratives.⁷⁵ The tendency to arrive at such conclusions also relates to the implications that institutions dispensing pauper charity were always a last resort for those who went there. Several historians contend that the almshouse was the ‘least preferred setting for medical treatment’.⁷⁶ Rosenberg also charges that historians who have approached this field have done so mostly as a ‘source of anecdote’ that fails to take proper stock of actual detailed practices. In a somewhat Dickensian approach, Richard Godbeer states that treatment for those with venereal disease at the Philadelphia Almshouse was ‘gruelling and ghastly’ and for prostitutes in particular it was ‘abrasive therapy’ that served as rough justice. This evidence is taken from the anecdotal notations left by the almshouse steward, discussed further in chapter six.⁷⁷ Conversely, Siena points out that the eighteenth century London Lock Hospital was not concerned with moral reform or correction. Yet because parish workhouses had a traditional disciplinary nature as well as providing relief, it was naturally assumed Lock hospitals followed suit.⁷⁸ This is an important point. Consequently, when historians of prostitution do acknowledge venereal disease, the assumption is that prostitutes were dispensed with a harsh dose of accordingly punitive medicine to punish their sins, almost always with the dreaded and poisonous mercury. Marcia Carlisle states that in Philadelphia ‘the only [venereal] treatment men and women received was mercury’.⁷⁹ This is another problem with the historiography on venereal disease and its treatment; for the most part historians proclaim that mercury was meted out as a blanket remedy, with little space given to differences in medical opinion and diagnosis of the various stages of disease.⁸⁰

Addressing the Historical Gap

⁷⁵ For example, Walkowitz contended that during the nineteenth century ‘repressive moralist views still influenced the treatment of syphilis and gonorrhoea...Because mercury application was very painful, it remained an appropriately punitive method of treating syphilitics’. Walkowitz, *Prostitution*, 55.

⁷⁶ For instance, see Rothman, *Discovery of the Asylum*, 45; Rosenberg, *Explaining Epidemics*, 182.

⁷⁷ Richard Godbeer, *Sexual Revolution in Early America* (Baltimore: John Hopkins University Press, 2002), 320.

⁷⁸ Siena, *Venereal Disease*, 190.

⁷⁹ Carlisle, ‘Prostitutes and their Reformers’, 49.

⁸⁰ See Katherine T. Corbett, *In her Place: A Guide to St. Louis Women's History* (St. Louis: Missouri Historical Society Press, 1999), 127; Ivan Crozier, ‘Sexuality’, in Stefan Bergar (ed.) *Companion to Nineteenth Century Europe, 1789-1914* (Oxford: Blackwell, 2006); Tony Henderson, *Disorderly Women in Eighteenth Century London: Prostitution and Control in the Metropolis, 1730-1830* (London: Longman, 1999), 39; Hill, *Their Sisters Keepers*, 233; Alison Jordan, *Who Cared? Charity in Victorian and Edwardian Belfast* (Belfast: Queens University Press, 2000), Mahood, *Magdalenes*, 36-7, 171; Rosenberg, *Care of Strangers*, 18; Siena, *Venereal Disease*, 124, 172, 253; Walkowitz, *Prostitution*, 52.

This dissertation explores the lives of Philadelphia's diseased almshouse women many of whom engaged in casual or more professional prostitution. This study is also about the many almshouse women who suffered from venereal disease who were not prostitutes. While the actions and attitudes of public officials will necessarily be accounted for, this will simply serve to capture the almshouse diseased woman and her experience. After all as John Parascandola explains, we understand and view diseases not as medical entities but rather, by the ways social, economic and cultural forces shape them.⁸¹ It is virtually impossible to separate a social history of venereal disease from women, sexual behaviour and attitudes of public officials. We can however distance our histories from the narratives of morality and regulation and explore other factors that shaped a woman's experience of prostitution and disease. Therefore, this discussion will keep the contexts of social control and moral correction firmly in the background, while bringing the prostitute and her experience of disease to the forefront.

Taithe suggests that historians of prostitution and venereal disease need to dig deeper in archival manuscripts to find lost historical actors in order to build a picture on how they were treated on the individual level.⁸² At many junctures of a diseased woman's use of the almshouse she has left evidence of the strategies she drew upon to gain treatment. Those who medically treated her have also left fragments of evidence that testify to the actual medicine she was prescribed. The following chapters will attempt to open up what are often quite cryptic documents, to reconstruct a picture of the almshouse venereal ward practices and procedures. This will add to the historiography that address's Ackercknecht's plea for a more critical analysis of what doctors actually did, rather than what they said. Ackercknecht pointed especially towards the use of medical 'case histories with data on treatment' to enrich the analysis of medical activities and patient medicines.⁸³ In order to dispel the myth that all cures were mercury, this also responds to Rosenberg's call for a closer look at the contents of physicians 'well- stocked pharmacopeia and armamentaria'.⁸⁴

⁸¹ John Parascandola, *Sex, Sin and Science, A History of Syphilis in America* (Westport: Praeger, 2008).

⁸² Taithe, 'Morality', 350.

⁸³ Quoted in Guenter B. Risse and John Harley Warner, 'Reconstructing Medical Activities: Patient Records in Medical History', *Social History of Medicine*, Vol. 5, No. 2 (1992), 184.

⁸⁴ Rosenberg quote from Michael McMahon, 'Beyond Therapeutics, Technology and the Questions of Public Health in Late Eighteenth Century Philadelphia', in Estes and Smith, *Melancholy Sense of Devastation*, 97.

On the one hand, the paucity of sources pertaining to pauper therapeutics can hamper such an investigation, yet a creative use of the available evidence can build a more comprehensive and detailed picture. In a short article pertaining to the existence of an almshouse casebook of James Rush (son of Benjamin) from 1819 to 1820, R.M. Price demonstrated the availability of related almshouse records in Philadelphia City Archives. Price proposed that ‘more information could certainly be gained’ with regards to medical practices and therapeutics in charitable institutions. Since this article appeared in 1985 there has been a poor response and in short, Price has been ignored.⁸⁵ This dissertation reveals that the almshouse was not always a last resort for a significant number of Philadelphia’s diseased women, and their decision to go to the infirmary was at times a first choice based upon shrewd judgement. This was in light of a woman’s knowledge and understanding of almshouse therapeutics. This conclusion is arrived at by combining a variety of sources that allow for the reconstruction of the ways women used the almshouse facilities. Moreover, from an examination of venereal ward medicines, which have provided a more detailed picture of pauper and prostitute therapeutics and physicians’ modes of practice, it is clear that prostitutes’ and diseased women selected the almshouse despite the range of alternatives.

This is not to overstate the comfort of the Philadelphia Almshouse. Philadelphia contemporary James Hardie could note with surprise of the city’s almshouse that, ‘the cleanliness attracts the attention of all travellers who unanimously declare that in this respect this institution exceeds anything in the Old World...and it is not surpassed by anything in the New’.⁸⁶ However a young Bostonian medical student wrote home from Philadelphia depicting the almshouse as a receptacle of ‘collective misery’.⁸⁷ Having said that, the Philadelphia almshouse infirmary was a sophisticated medical provider for its time, and its wards were staffed by some of the country’s best apothecaries, physicians and surgeons. In sum, there is a large gap on the history of

⁸⁵ R.M. Price, ‘A Case Book of the Philadelphia Almshouse Infirmary: Dr. James Rush Attending Physician, October 1819 to February 1820, *Bulletin of the History of Medicine*, Vol. 59, No.3, (Fall, 1985), 383-89.

⁸⁶ Quote from Hunter, ‘Origins’, 47.

⁸⁷ Leonard K. Eaton, ‘Medicine at Philadelphia and Boston, 1805-1830’, *Pennsylvania Magazine of History and Biography*, Vol. 75, No. 1 (1955), 68.

early American institutional medicine for the poor, as well as that of the prostitute experience. Both issues can be studied together.

Thesis and Chapter Outline

The time-frame of this dissertation is loosely defined in that it is not set within specific 'era' parameters, and for the most part, the discussion is based on early national period leading into the antebellum years. This is partly because of the nature of the available almshouse sources, which are especially rich from 1790 to c.1830. This was also an important time when familial relationships and sexual behaviours were changing significantly in America's most urbanised areas. Such changes were instigated by the Revolution, alongside economic and ideological shifts. Moreover, this was also a transitional period for medicine and medical practices, as doctors increasingly departed from the use of heroic therapeutics in favour of treatment less invasive on the patient. Out of necessity, there may be some overlap between chapters, or repetition of sources to reinforce an argument. The following chapters will ask various questions related to diseased almshouse women. Who were the prostitutes and diseased women who used the almshouse? What were their medical histories? What were the long and short-term effects of venereal disease? What actually happened when a woman went to the almshouse and entered the venereal ward? What was she medically treated with? And how did she respond to this? Part One will explore the cultural, economic and social context of diseased almshouse women's lives. This will necessarily involve discussions of prostitutes and prostitution, as well as considering the lives of women who caught infection from their partners. Part Two will account for the medical context of diseased women.

Chapter One will outline biographical histories of diseased almshouse women, and consider the economic, social and cultural aspects of the lives of those who engaged in prostitution and also sought treatment as diseased paupers. Like Rachel Ward, many women who used the infirmary's facilities in the almshouse lived much of their working lives moving between or within the city's various institutions as they struggled to survive. Chapter Two will lay out the administrative environment of the almshouse. Although this does outline the attitudes of those in positions of power, this account is essential for its illustration of why diseased women, (who were often

perceived as socially problematic and marginal) were able to take advantage of the medical resources, and to a large degree control the conditions of their own almshouse experience. Chapter Three will then seek out the voices and attitudes of diseased almshouse women, in order to explore the ways they experienced and responded to incarceration. This will involve tracing the movements of a number of diseased almshouse women and illuminate how they were able to create their own space inside its walls, and often influence the terms of their confinement. I will argue that a significant number of women exploited almshouse resources to a larger degree than other inmates. This involved drawing upon a range of strategies to negotiate use of the almshouse infirmary. This chapter will additionally account for the support networks cultivated by women inside the venereal ward. Based on an interpretation of the sources, I argue that “communities” of diseased almshouse women hailing from different Philadelphia districts often came together and formed bonds in the almshouse, and these relationships were then maintained on the streets.

Chapter Four will provide a tour of the city’s many outlets of medical provision available to the venereal shopper. Diseased women had recourse to medicines from professional physicians and surgeons; apothecaries; midwives; female healers and self-styled doctors, some quackish and others genuine. Philadelphia’s marketplace was crowded with self-made healers, yet for the syphilitic customer often commercially available remedies were more likely to kill than cure. Mercury was cheap and easy to come by, yet it was often disguised in the form of various more palatable sounding pills and potions. This chapter will also address how well placed women were to gain reproductive advice on fertility control or abortion. Some diseased women did clearly draw upon the community’s wider provision of medical care. This is confirmed by the Daily Occurrence Dockets that reveal women turned up at the infirmary for the first time in a deplorable state of health, often the result of mercury poisoning. Yet this only tells part of the story, and the larger picture illustrates that a significant number of women used the resources at the almshouse infirmary for a short spell of treatment for mild forms of disease, and seem to have returned to their lives either restored to health or free from visible infection and feeling well again. They were able to do so in light of the mild nature of therapeutics carried out by almshouse physicians as the last two chapters will highlight. Chapters Five and Six will attempt to build a picture of the almshouse venereal ward and the

treatments carried out there. Chapter Five will explore individual almshouse doctor's attitudes toward venereal disease and its treatment. The historiography often regards Benjamin Rush as typical of contemporary American doctors, characterizing them as hell-bent on administering abrasive and interventionist depletive therapy in the belief that this was the most effective means of medical treatment. Yet a significant number of Philadelphia doctors were more sensitive to the needs of their patients, including women with venereal disease. According to John Duffy, Rush was 'scarcely typical of early American physicians' and,

...the work of the French Clinical School, the observations of intelligent physicians, and the impact of yellow fever all played a role in helping to bring about the transition from excessive and drastic forms of therapy to a policy of moderation and support for the patient.⁸⁸

This chapter will provide an analysis of the lecture notes of almshouse physicians and their views on venereal treatments. Chapter Six will go on to explore whether doctors' articulations actually translated into practice inside the almshouse venereal ward. The sources reveal that for financial considerations and individual doctor's medical opinions, when mercury was dispensed in the almshouse infirmary it was done so as a last resort with minimum application.

A Note on Linguistics and Terminology

Although the labels referring to women in this study may appear crude or perhaps even derogatory, I use such expressions merely for simplicity's sake. In short, adopting such phraseology facilitates smoother composition on the part of the author. Thus, I use stock-phrase categories such as 'diseased almshouse women', 'venereal women' and 'diseased paupers'. It is hoped such labelling will not objectify the women involved in this study given that the overall aim is to put a human face on prostitutes and women suffering from venereal diseases. My intention is to illustrate women's circumstances with enough examples that will prevent draining them of personality or render them abstract metaphors.

⁸⁸ John Duffy, *From Humors to Medical Science: A History of American Medicine* (University of Illinois, Press, 1993), 77.

There are naturally difficulties inherent with such a study that draws upon current medical knowledge to interpret retrospective analyses of a single disease entity, we now separate as different diseases with distinctive stages. As Siena reminds us, the medical profession often spoke of one venereal disease to label several conditions.⁸⁹ As historians we need to decode the descriptors of disease (often used in couched terms) employed by contemporaries that could often hold a variety of meanings. For instance, while the clap was used by some people as a reference to primary syphilis or gonorrhoea, others used it as a blanket term to signify a single venereal disease. In short, medical terminology relating to gonorrhoea and syphilis was used interchangeably. Therefore, at times we need to use the terminology or euphemisms of contemporaries to explain their histories. Thus, I will often refer to the symptoms and stages of venereal diseases exactly as contemporaries articulated them.

A Note on Methodology and Sources

There are countless potentials and pitfalls intrinsic to the use of the source materials consulted. Counting prostitutes in early America is virtually impossible, and there is no way of knowing how representative almshouse women were of Philadelphia's prostitute population given that the majority remain obscured by the historical record.⁹⁰ It is difficult to uncover the experiences of the lower sort at the best of times let alone those engaged in clandestine operations. Yet a study concerned with those who were diseased and went to the almshouse infirmary for treatment does provide a larger sample of prostitute's than the current historiography from Philadelphia. When discussing "prostitutes" I have considered those who I suspect were prostitutes, however casually they engaged in the occupation. The ambiguous nature of much of the data implies that prostitution as a categorical occupation is problematic in its definition, especially so given the profession's fluidity. A significant number of women who entered the almshouse may have dipped in and out of casual prostitution when needing temporary funds.

⁸⁹ Siena, *Venereal Disease*, 15.

⁹⁰ For example, those working as elite prostitutes or courtesans are hidden for the most part. Although this group are hard to locate they may have fallen down the social ladder after being infected, as would diseased women who were shunned by family or friends and left to fend for themselves. Thus diseased almshouse women were not always initially drawn from the lowest ranks of society.

My research was conducted by employing a combination of archival materials sourced in several public and private depositories, mostly located in Philadelphia. Evidence in Part One is drawn for the most part from the Guardians of the Poor Daily Occurrence Dockets and data from related almshouse admission registers. These are augmented by the Overseers of the Poor Vagrancy Dockets. Despite Docket notations being sparse in biographical detail, often containing stock phrases. The records are nevertheless a rich source when cross referenced with related sources. The qualitative nature of the earlier records in the 1790s, together with the derogatory language indulged by the almshouse steward often makes for assumptions rather than definitive conclusions. Naturally, research undertaken with the attempt of recovering pauper agency is limited to consulting the sources generated by those in positions of power. However, read critically they provide a fuller representation and understanding of actual experience. While such records often carried the moral judgements of the authors that created them, they nonetheless reveal much about the lives and material existences of diseased almshouse women. Given that the Dockets are tainted with the prejudice of an official there is no verification of the authenticity of women's voices. Thus we cannot be sure how an almshouse woman really felt or even responded to scrutiny of her personal life, particularly in light of the nature of what could potentially be quite embarrassing symptoms of disease. The records post-1800, although less complete with textual information, allow for more statistical observation.

While trawling through the huge ledgers of the almshouse's Managers' and Physicians' Minutes and the steward's Dockets it became clear that actual therapeutic practice was rarely referred to, and when it was, it was either a fleeting anecdotal reference or in relation to the supposed economic drain on resources by patients and physicians. In Part Two I realised I would have to dig deeper if I wanted to find out exactly what happened in the venereal ward. The sources used to create a picture of prostitute medicines in the ward naturally have their limits. Nonetheless by researching a variety of records -many of which are untapped source materials- I collected enough data to permit a detailed evaluation. One of the most trying aspects was coming to terms with historical pharmaceutical terms, as well as deciphering pharmaceutical short-hand. Nevertheless, with the help of a trained pharmacist I persevered until I became confident in both translating contemporary apothecary and physician's prescriptions and indeed understanding the purpose that specific medical

practices and drugs served. Without such help, this part of the thesis would have been impossible.

Methodology is often hampered by a lack of diagnostic confirmation. While many women were admitted with ‘ulcers’ they may well have been venereal cases. And in a similar vein, those deemed venereal were often likely to be suffering from common ulcers. A significant proportion of Philadelphia’s prostitutes only engaged in casual prostitution, perhaps only on one occasion only. The records are flawed in many instances given that administrators did not enter patient details accurately. As historians we are frustrated by incomplete records, yet it would appear those who governed the almshouse despaired at poor record-keeping. In the medical department, clerks and students were required to keep registers of admissions and discharges. Yet as one apothecary complained,

The late junior student neglected to perform the part of duty, which would have induced him, if he had been in his right mind, to have recorded all the cases occurring in this Institution out of the Sick and Surgical wards in our book kept for that purpose; which circumstance has given rise to much trouble to me.⁹¹

Many women who were healed relatively quickly may have returned to their normal lives without engaging in prostitution again, or if they did, they may have remained free of disease. I have constructed a database spanning a period of over forty years to account for possible readmissions even decades after first treatment at the infirmary. The figures however cannot be definitive; some women used alias names and it is not always possible to connect such women. Much of my evidence is derived from computer-aided database software, which has been invaluable for the creation of partial biographies. For the most part this is used for ease of analysis by linkage of a variety of sources where diseased women appeared, which therefore made the task of compiling social and medical biographies a more straightforward and speedier task. The databases have also enabled me to trace diagnostic information through various admission registers in order to evaluate specific stages of disease in the medical case notes left by physicians, although this is done so only as far as the sources will allow.

⁹¹ Guardians of the Poor, Philadelphia Almshouse Hospital Apothecary’s Register, Sick and Surgical Ward Patients, 1800-1803, 23 May, 1803.

I have often arrived at different figures than previous historians using similar sources for different purposes. When accounting for numbers of almshouse inmates, I have included venereal women who were admitted with ulcers but turned out to be infected with venereal infection upon discharge. I traced this by cross-referencing the docket records with other admission registers and censuses. This is important because some female venereal admissions were not noted in the daily occurrences.

I have additionally used city census and trade directories to enable me to profile and reconstruct the neighbourhoods of diseased women. There are naturally many problems associated with this kind of source material. Above all, lower class women are under-represented and in the trade directory most remain hidden, unless they headed their own business. Yet those who carried out covert medical trades are generally not listed. Moreover, a woman listed as midwife for instance could carry out a range of tasks and to this end the directories can only be used as rough guides given that contemporary labelling could hold a range of meanings.

PART ONE

Chapter One

Setting the Scene: a Social Profile

1.1 Diseased Women: a Range of Experience

Several images spring to mind when we think of diseased women or prostitutes in the late eighteenth and early nineteenth centuries. Perhaps we imagine *Charlotte Temple*, the heroine of the most commercially successful seduction novel in Early America. Deserted by her seducer, Charlotte's sexual transgression leads to unwanted pregnancy and remorse, culminating in her premature death. Susannah Rowason presents Charlotte as the victim of male sexual license.⁹² We might also think of the 1797 poem *The Dying Prostitute, An Elegy*, one of the earliest portrayals of prostitution in literature. In this narrative, the prostitute acknowledges her victimization, blaming villainous male exploitation for her life of sin.

Ah! Say, insidious Damon! monster! Where?
What glory hast thou gain'd by my defeat? ⁹³

The kinds of images conjured up in the journal of preacher Ezra Stiles Ely may also be familiar. On his evangelical visits to the inmates of New York's almshouse, Ely found 'the ward of courtesans...a grand receptacle of withered, dying females...on beds of disease planted with thorns'.⁹⁴ Perhaps the most familiar images of eighteenth century prostitution were those produced by William Hogarth in his series of prints, 'A Harlot's Progress'. Although a comical representation of prostitution, Hogarth intended to communicate a moral message against 'the kind of society that lured innocent victims to destruction [and] allowed exploitation of the poor and helpless by the rich and influential'.⁹⁵ In the first image of the series, Hogarth portrays a country

⁹² Susannah Haswell Rowson, *Charlotte Temple*, edited with an introduction by Cathy N. Davidson (Oxford: Oxford University Press, 1986); Clare E. Lyons, *Sex Among the Rabble: An Intimate History of Gender and Power in the Age of Revolution, Philadelphia, 1730-1830* (Chapel Hill: North Carolina University Press, 2006), 316.

⁹³ *The American Museum or Repository of Ancient and Modern Fugitive Pieces, Prose and Poetical* (Philadelphia, 1787).

⁹⁴ Ezra Stiles Ely, *Visits of Mercy: The Journal of the Stated Preacher to the Hospital and Almshouse to the City of New York* (New York, 1811), 26, 138.

⁹⁵ According to Fiona Haslam, while Hogarth's depiction of prostitution in London is an attack on those who lured young, innocent country into prostitution, the artist also criticizes the pretensions of young girls who aspired to be kept as ladies. Thus, the prostitute is 'not absolved from all blame... [and her] untimely death may be seen as apt punishment for moral laxity'. Fiona Haslam, *From Hogarth to Rowson: Medicine in Art in Eighteenth Century Britain* (Liverpool: Liverpool University Press, 1996), 89. On the importance of Hogarth's prints as an historical representation of prostitution see

girl Moll Hackabout arriving in town searching for work as a seamstress. However, the pox-ridden brothel-keeper, Mother Needham, lures the young women into a life of prostitution. Needham acts for the convicted rapist Colonel Charteris, who, as a pimp, lurks in a nearby doorway ready to pounce on the innocent Moll. The series ends with the prostitute's subsequent and inevitable fall from grace into a life of disease and impoverishment.



Figure 2: William Hogarth, *A Harlot's Progress*, Plate 1: 'Arrival in London'.

While most of these accounts are predominantly fictional and highly stylised, they all share the notion of the prostitute as a victim of male seduction. Moreover, like many popular seduction narratives of the period, the main female character is drawn from the middling or upper classes. In America's new republic, novels like *Charlotte Temple* were highly popular amongst Philadelphia's better sort, intended to reinforce a new social construction of Republican womanhood. *Charlotte Temple* and similar narratives acted as cautionary tales; instruments of 'middle class conformity' acting as 'subtle warnings' to those whose dowries were limited.⁹⁶ Yet such fictional accounts tended to ignore the poverty that characterised a woman's life in the *first* instance. Moreover, space was rarely devoted to female agency within these narratives. This

Sophie Carter, *Purchasing Power: Representing Prostitution in Eighteenth Century English Popular Print Culture* (London: Ashgate 2004).

⁹⁶ Jan Lewis, 'Republican Wife: Virtue and Seduction in the Early Republic', *William and Mary Quarterly*, 3rd ser., No. 44, (1987), 715. For further examples of contemporary popular print conveying similar moral messages see Cathy Davidson, *Revolution and the World: The Rise of the Novel in America* (New York: Oxford University Press, 1986); Lyons, *Sex Among the Rabble*, 313-22.

was not lost on the author of the article entitled ‘Rationale of Seduction’, which appeared in the *Pennsylvania Public Ledger* in 1837. According to the author,

...the poor unfortunates who crowd our streets and theatres...have rarely, in the first instance, been corrupted by love, but by the contagion of circumstance and example... it is a miserable cant phrase to call them the victims of seduction...they have been the victims of hunger...and of curiosity.⁹⁷

While prostitutes inflicted with disease may have shared some aspects of the lives of our fictional characters, what is missing from the imaginative accounts above is the full scope of female experience.

The extraordinarily rich archival records for Philadelphia’s early national period and beyond allow us to create a far richer and more nuanced image of prostitutes living in the urban republic, and the almshouse records reveal a more wide-ranging experience. The aim of this chapter is to bring to life the city’s prostitutes and women suffering from venereal disease.⁹⁸

⁹⁷ *Pennsylvania Public Ledger*, December 15 1837, Historical Society of Philadelphia. (hereafter cited as PPL and HSP)

⁹⁸ This analysis aims to enhance recent historiography that uncovers the lost voices of the Philadelphia poor. Simon P. Newman, *Embodied History: The Lives of the Poor in Early Philadelphia* (Philadelphia: University of Pennsylvania Press, 2003); Billy G. Smith, *Down and Out in Early America* (Philadelphia: Pennsylvania University Press, 2004); Billy G. Smith, *The Lower Sort, Philadelphia’s Laboring People, 1750-1800* (New York: Cornell University Press, 1990). As Billy Smith notes, historians of America are behind their English counterparts in mining the various records from networks of authority in an effort to reclaim the plebeian life and experience. One of the best English works which recovers the lives of those usually obscured is Tim Hitchcock, *Chronicling Poverty, the Voices and Strategies of the English Poor, 1640-1800* (Basingstoke: Macmillan Press, 1997).

One summer's night in 1794, Mary Carlisle was walking the streets of Southwark, a working class suburb of South Philadelphia, in an attempt to drum up business. She was accompanied by Hannah Bond, Mary Cope and Sarah Evans. All four women were 'apprehended by the watchmen at a late hour of the night' and charged for 'being idle lewd and disorderly women'. This was not the first time Mary Carlisle had come into contact with the public authorities. In January 1791 she had been admitted to the almshouse as a 'stout healthy looking young woman...with a sore finger'. A month before, she was 'charged with being a common and abandoned prostitute...to be kept [at] hard labour one month' in the Walnut Street Jail. Between 1790 and 1796 Mary was arrested twelve times. Frequently drunk when picked up by the city watchmen, she and her companions were often arrested for being 'disorderly vagabonds...nightwalkers [and] common prostitutes'. Mary was sixteen years old when she first applied for almshouse assistance, and from then until her death in April 1804, she became well known to the almshouse authorities, as a 'ven[era]l hussey frequently in here & always in that way'. While we have little background biographical information about Mary, it is clear that she engaged in prostitution from a young age. Perhaps she was an orphan, or alternatively had run away from the family or her master's home in the countryside in search of the freedom of opportunities, and the excitement of the seaport city. Mary apparently never married and she was part of a highly visible and large community of Philadelphia prostitutes who appear in the records of the city's almshouse and jail. It is also clear that while Mary had appeared 'stout and healthy' during her first few almshouse admissions, disease caught up with her quickly. After 1794 she would often be noted as 'vile...sick and diseased' in her appearance. That she was arrested so often on the streets suggests she could not find employment in any of Philadelphia's many brothels. The best custom she could probably hope for was either to be had on the streets or in the city's lowest oyster bars or tippling houses. These "dens of iniquity" as upper class contemporaries referred to them, were located near the waterfront and down the city's many crowded and dirty alleyways in Southwark and the Northern Liberties, where sailors and labourers mostly congregated.⁹⁹

⁹⁹ Mary Carlisle, 19 Jan. 1791, 17 Jan. 1792, 22 Nov. 1792, April 1793, Feb. 1794, July 1794, 19 Dec. 1800, 5 Mar. 1801, May 1801, 16 Dec. 1801, 6 Jan 1803, Dec. 1803, 8 April 1804, 10 April 1804,

On 6 September 1801, while Mary Carlisle was being treated for venereal infection as ‘a polishing room customer’, a blind child ‘between five and six years’ was admitted to the children’s ward of the almshouse. Ann Oakman had been taken from one of Philadelphia’s numerous brothels in Southwark. The previous day her mother, twenty-nine year old Lydia Oakman had been sent to the city’s Walnut Street Jail on account of ‘keeping a bawdy house’, which occasionally erupted in riot. The following April after serving her time in the workhouse, Lydia herself sought medical treatment where her unfortunate young daughter was ‘still in this house’.¹⁰⁰ Eager to gain admission and treatment, and pregnant with another child, Lydia claimed that ‘her husband went to sea seven months ago [and] the vessel was cast away...and she has not heard of him since’. It is not clear how long Lydia spent in the almshouse on this occasion, although she turned up again seeking medical aid three years later, and her admission suggests this may have been the result of an aborted pregnancy. The fate of her child Ann Oakman is also unclear.¹⁰¹ Lydia Oakman’s house of ill repute was located in the Southwark district of Philadelphia. This was a working class area, and was filled with oyster bars, dram shops and taverns frequented by members of the lower sort. As a brothel madam Lydia no doubt possessed a certain degree of dexterity in order to manage her establishment, and she no doubt previously worked as a prostitute herself. She may actually have been relatively financially secure in her early career, especially by comparison with Mary Carlisle. However, she may have progressed to a stage of venereal disease that rendered her incapable of treating herself at home, or perhaps she was unable to afford or secure a bed in the Pennsylvania Hospital. Although some of the medical profession actually visited brothel madams in need of treatment, physician’s fees for home visits were high.¹⁰² With a blind child to care for, (and presumably another infant by now) Lydia may not have been wealthy enough to pay the doctor’s fees, thus she was reduced to seeking treatment in the almshouse again. Alternatively, perhaps she indeed headed straight to the almshouse infirmary in the first instance, regardless of what she could afford.

Dockets; 30 Oct. 1790, 6 June 1791, 19 Apr. 1792, 13 Oct. 1792, 22 July 1792, 24 Mar. 1794, 11 May 1795, Aug. 1795, 7 Sep. 1795, 7 Dec. 1795, Vagrancy.

¹⁰⁰ Philadelphia’s jail was also referred to as the workhouse.

¹⁰¹ Ann Oakman, 9 Sep. 1801; Lydia Oakman, 29 Apr. 1802, Oct. 1805, Dockets.

¹⁰² Patricia Cohen, *The Murder of Helen Jewett* (New York: Vintage Books, 1999), 108.

Several years later, nineteen year old Sarah Thompson made her way to the same area where Lydia Oakman's brothel had been located. Sarah was divorced from her husband, and near destitute. She had migrated from New Jersey and began work as a prostitute in Philadelphia, presumably to augment the meagre wages she earned as a domestic servant. It is not clear where and when Sarah first started plying her trade, but she eventually conducted her business from a brothel. Unlike Lydia Oakman, Sarah was childless, and therefore as a single woman had her pick of brothels. In seeking out her workplace in Southwark, she almost certainly passed Nancy Green's brothel 'between 4th and Shippen', or Julien Nixon's house of assignation at '88 German Street'. She may also have passed, or even worked at 'Sarah Cooper's bawdy house in German Street', before settling upon a brothel in Plumb Street. According to an almshouse official, Sarah was 'living in various places' without resources by the time she was admitted to the almshouse in 1811. Her last known residence was 'with Hannah Hughes in Plumb Street...who she says keeps a House of Ill Fame'.¹⁰³ Unlike Mary Carlisle, Sarah seems to have kept out of trouble and by all accounts she appeared to almshouse officials as a character ripe for moral reform. After two months of treatment in the venereal ward, Sarah and three other young girls were sent to the Magdalen Asylum. Sarah does not appear again on the public records, so perhaps she was able to return to her former life as a domestic servant.

While the above diseased women all engaged in prostitution and all spent time in the venereal ward of the Philadelphia almshouse, they were indeed three very different women, each with their own distinct stories to tell. Twenty-nine year old Lydia Oakman, a brothel madam and mother to a disabled child who was also pregnant again, and alleged that she had been deserted by her husband; divorced nineteen year old Sarah Thompson, a prostitute who worked in one or several brothels who went on to Philadelphia's Magdalen Asylum; and eighteen year old Mary Carlisle, an unmarried and lowly streetwalker who was frequently in trouble with the law and who spent far more time than the others institutionalised in the almshouse and prison workhouse. While they no doubt entered the world of prostitution for different reasons and conducted their work in different ways, the common thread linking these women was venereal infection and almshouse incarceration. These personal

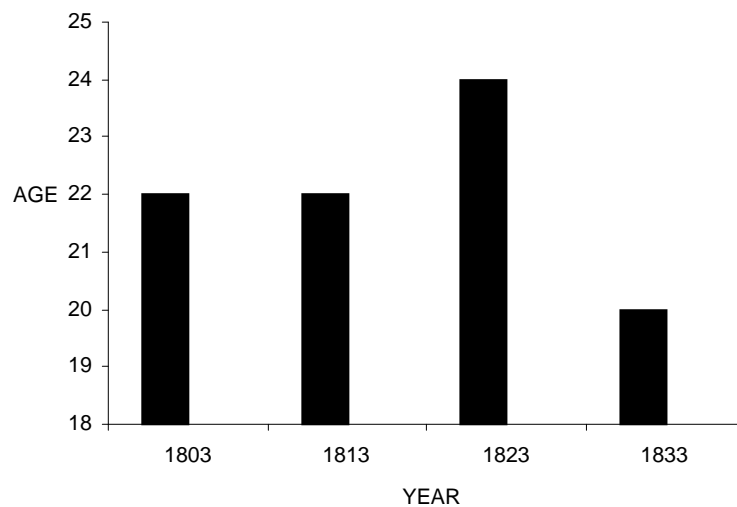
¹⁰³ Sarah Thompson, 11 Dec. 1811, Dockets.

biographies will be a useful reference point as we consider the experiences and range of circumstances surrounding the lives of female venereal almshouse patients in late-eighteenth and early nineteenth century Philadelphia.

1.2 ‘don’t appear to be more than seventeen’

Who were Philadelphia’s diseased almshouse women? A survey of a two-month period taken from the Daily Occurrence Dockets and Almshouse Weekly Census reveals the age range of such women. On 27 May 1812, Eliza Ross arrived at the almshouse seeking medical treatment. Eliza was twenty years old and separated from her husband. She was moved into the venereal ward where she joined Sarah Peterson, an eighteen year-old. Next to arrive was Elizabeth King a twenty-nine year old who, ‘says she has sores’. Elizabeth denied that her sores were syphilitic, yet she was admitted into the polishing room as a venereal patient. Eliza was then discharged at the end of June on the same day that eighteen-year-old Isabella Johnson arrived. On 1 July Catherine Byron was admitted to the venereal ward, as a nineteen-year-old ‘former customer’. When previously discharged, Catherine had been sent from the almshouse to the Magdalen Asylum, presumably because in she had been deemed a perfect candidate for reform. Yet she now returned for further medical treatment. A few days later while the citizens of Philadelphia were revelling in the Fourth of July celebrations, Catherine, Isabella and Sarah were joined in the venereal ward by twenty-four-year old Elizabeth Maxfield. Another ‘former customer’, Elizabeth ‘return’d sick supposedly venereal’. Ten days later, Ann Chapman yet another former inmate, arrived in a ‘high state of venereal’. Ann was only fifteen years old.¹⁰⁴

¹⁰⁴ May to July, 1812, Dockets and Guardians of the Poor, Philadelphia Almshouse Weekly Census and Admissions 1812, PCA.



Graph 1: Average Age of all Female Venereal Admissions in Philadelphia Almshouse during sample years. Source: Guardians of the Poor Female Register; Guardians of the Poor Daily Occurrence Dockets Guardians of the Poor Weekly Admission and Census, PCA.

Female venereal inmates were for the most part young women in their late teens and early twenties. Barbara Hobson has noted that ‘an almost universal social fact about prostitution ...is the degree to which it is an occupation of young women’. In her study of Boston prostitutes incarcerated in the House of Correction during the mid-nineteenth century, Hobson found the average age to have been twenty-one.¹⁰⁵ The average age of prostitutes in the Philadelphia almshouse appears to be slightly higher than in Boston with an average age of twenty-two years. The peak average age of twenty-four in 1823 may be attributable to the after-effects of the economic panic in 1819, with a recession that lasted until around 1823.¹⁰⁶ When unemployment and poverty loomed larger, older women who did not normally resort to prostitution may have done so as a temporary means of keeping themselves and their families afloat.

Some girls were disturbingly young when first afflicted by venereal disease. In 1813 Eliza Hordner, only nine years old, was admitted to the almshouse with venereal infection. It was noted that Eliza was ‘ill treated by her mother [whose] husband keeps a house of ill fame’. Although an extreme case, the surviving records clearly

¹⁰⁵ Hobson, *Uneasy Virtue*, 86.

¹⁰⁶ Interestingly, there was a surge in total numbers of venereal admissions during this period.

indicate that venereal disease was prevalent amongst numerous females we now think of as young teens. Historians of prostitution have shown that in New York City, brothels existed that were dedicated to prostitutes between ten and fourteen years of age.¹⁰⁷ There is also a good chance that disease was inherited from an infected mother rather than simply a case of child prostitution. Moreover, venereal patients identified in the records as young girls may well have caught infection as a result of sexual encounters that were not strictly consensual. It is extremely difficult to actually identify incidences of sexual abuse or rape in the records.¹⁰⁸ As Sharon Block points out, in early America sexual coercion may have manifested itself frequently, with masters ordering their 'labourers into sexually vulnerable situations'.¹⁰⁹ As is well known, the racial slave system was characterised by high incidences of rape, with masters sometimes exercising their assumed sexual prerogative towards slave women. The almshouse records suggest that sexual coercion of very young women may have been far more common than historians have realized, with most of the victims being either indentured or wage earning girls. When diseased Harriet Bunkhart was admitted in 1811 it was noted that 'her master will pay her board'. Scores of young women arrived at the almshouse in a similar situation, and we are left to wonder if masters were paying for the treatment of diseases that they or their kinsmen had cause.¹¹⁰ Had nine year old Jane Clark, indentured to 'the owner of a brothel' been raped, and had fourteen-year-old Eliza Williams suffered the same fate in her place of service?¹¹¹ The paucity of evidence allows us to do no more than speculate about what had happened and about how far a young woman or girl would go to hide the events that led to their being diseased. Moreover as Block reminds us, servants were dependable on the board or wages provided by their masters, thus making it difficult to make accusations of sexual abuse.¹¹²

¹⁰⁷ Judith Kelleher Schafer, *Brothels, Depravity and Abandoned Women: Illegal Sex in Antebellum New Orleans* (Baton Rouge: Louisiana State University Press, 2009), 47.

¹⁰⁸ Lyons identifies only twelve incidences of rape in the arrest records during the 1790s, and of those the majority of prosecutions involved child victims of black men. Lyons, *Sex among the Rabble*, 251.

¹⁰⁹ Sharon Block, *Rape and Sexual Power in Early America* (Chapel Hill: University of North Carolina Press, 2006), 54.

¹¹⁰ Harriett Bunkhart, June 1810, Dockets.

¹¹¹ Nancy Roberts, 13 July 1839, Eliza Williams, May 1810, Jane Clark, Aug. 1808, Sarah Johnson May 1802, Dockets.

¹¹² Block, *Rape and Sexual Power*, 97.

A large number of venereal patients were also young orphans. As a result of several devastating yellow fever epidemics during the 1790s, a multitude of children attempted to survive on their own. When Amelia Barrett was left ‘without parents’, she was ‘bound’ to a master who kept a brothel. Mary caught venereal disease when she was fourteen and she subsequently ended up in the almshouse. Similarly, Sarah Ferguson ‘has the venereal disease and don’t appear to be more than seventeen...her parents...have been dead for three years’. After her parents had died, Sarah was a ‘wanderer through the streets...having no place to lay her head [and] has been exposed to every vile temptation being thus situated’. Exposure to the world of sexual commerce affected many vulnerable young girls and women in Philadelphia. Like Amelia and Sarah, other orphans and young women living away from parental and family care were susceptible to the enticement of prostitution. This was particularly the case for those living in the city’s working- class neighbourhoods where brothels were more concentrated. Nineteen-year-old Mary Fitzsimmons, for instance, lived away from her family while working for ‘her master Mr. Dougherty at 11th Street near Cherry Street who keeps a liquor store’. Mary resided and worked in a poor neighbourhood, populated by labourers and public women. Cherry Street was sandwiched between the Mulberry (now Arch) and Sassafras (now Race) wards, an area in the north of the city once known as ‘hell-town’. Mary’s surroundings were a haven for ‘Philadelphia’s underclass: criminals, alcoholics, vagrants, prostitutes and itinerants, as well as many unfortunate ‘men and women who were generally down and out’.¹¹³ How Mary came to be infected with venereal disease is not clear, although it is quite possible that she engaged in some form of prostitution.

1.3 ‘just landed in Philadelphia’

While data regarding diseased women’s age is fragmentary, other demographic information is somewhat more complete.¹¹⁴ Elizabeth Douglass’s story was typical of many white migrants. A Maryland native, Elizabeth was eager to leave the

¹¹³ Amelia Barrett, Nov. 1804, Sarah Ferguson, 9 July, 17 July, Aug. 1800, Oct. and Dec. 1803, Mary Fitzsimmons, 24 Aug. 1811, Dockets. Geographical information taken from Billy Smith, *Lower Sort*, Chapter One: ‘Walking the Streets’. Quote from p.21. For a discussion of the area of labelled by contemporaries as ‘hell-town’, see Sharon Salinger, *Taverns and Drinking in Early America* (Baltimore: John Hopkins University Press, 2002), 233.

¹¹⁴ The sources are more informative from 1800, and this may be in light of the public authorities’ ever-increasing obsession with admitting only those people with legal residence.

countryside behind her in search of adventure in Philadelphia's bustling metropolis. In 1797 'she was brought to this city by her Cousin...a driver on one of the Stages'. However, Elizabeth had not been in the city long before she was forced to turn to poor relief, and according to the almshouse steward, 'she was immediately bruthensome to the Publick'.¹¹⁵ Numerous venereal inmates were noted in the dockets as having arrived in the city from other areas of Pennsylvania, and also other states and countries. However, the streets of Philadelphia were not paved with gold as some young women believed, and as Shammas points out Philadelphia's poverty rate was three times higher than that of its adjacent counties.¹¹⁶ While the city appeared to offer more economic opportunities and enticements, country girls relocating to the urban environment became both economically and socially vulnerable.

The same was true for European immigrants. Despite being outnumbered by white native-born Americans, diseased women of foreign birth were nonetheless a significant presence in the almshouse, as illustrated in Table 1 below. This is not surprising given that 'the labouring poor had a distinctive ethnic composition...with a large number of them blacks or recent immigrants'.¹¹⁷ Sophia Curry's fate was typical of that of a large number of young immigrants arriving in Philadelphia. Seventeen-year-old Sophia travelled from Liverpool in 1798 in search of a more promising life. She worked 'as maid with different families' yet within four years venereal disease had rendered her 'incapable of work'. She was admitted to the almshouse for medical treatment no less than nine times. Like Mary Carlisle and her friends, Sophia clearly enjoyed Philadelphia's nightlife, and she was arrested by the watchman as a 'common disturber of the neighbourhood'. Often 'intoxicated', she was 'picked up in the street and sent to the sick ward'.¹¹⁸

¹¹⁵ Elizabeth Douglass, 8 Feb, 1797, Dockets.

¹¹⁶ Carole Shammas, *History of Household and Government in America* (Charlottesville: University of Virginia Press, 2003), 114.

¹¹⁷ Clement, *Welfare and the Poor in the Nineteenth Century City: Philadelphia, 1800-1854* (Rutherford: Farleigh Dickenson University Press, 1985), 31.

¹¹⁸ Sophia Curry, Aug. 1803, Apr. 1804, Dec. 1804, Jan. 1807, July 1807, Nov. 1807, July 1809, Oct. 1809, Jan. 1811, Feb. 1811, Dockets. 15 July 1806 Vagrancy.

	1800	1808	1820	1825
Native white	66	50	64	51
Black	21	29	20	21
Irish	10	15	11	24
Other foreign	3	6	4	4

Table 2: Ethnicity of Female Venereal Almshouse Admissions (% of total)

Source: Philadelphia Almshouse Admissions Books, 1785-1827; Weekly Census and Admissions; Female Receiving Register 1800-1830. Guardians of the Poor, Philadelphia Almshouse Hospital Weekly Return of Patients in Sick and Surgical Wards, PCA. Only patients listed as having syphilis or gonorrhoea have been included. Patients identified with ulcers were omitted, although they may have been venereal cases. In 1810 for instance, an additional 190 patients were listed with ulcers.

From the late eighteenth century on, an increasing number of Irish immigrants arrived in Philadelphia, and after 1800 immigration from Ireland escalated at an astounding rate. Thereafter, the Irish became the single largest immigrant group in Philadelphia, and they came to dominate the foreign-born population.¹¹⁹ Irish women in particular flocked to America's cities in search of employment, yet when they could find work it was mostly in unskilled menial jobs. Consequently, many unfortunate women found themselves facing the same harsh conditions they had left behind in their native land.¹²⁰ With disproportionately more Irish women than men chasing jobs, these women practically formed a distinct class of their own. This did not go unnoticed by the city's more prosperous citizens, and contemporaries spoke of the Irish women who 'beg in the streets, aggressively pleading their cases with pronounced brogues'.¹²¹ As Amy Gilman has suggested, Irish women were perceived by the better sort as 'personifications of wretchedness [being] separated from the mainstream into a social and sexual class unto themselves'.¹²²

Yet, while the first-generation Irish constituted a significant presence in the almshouse, those admitted as venereal patients were not as numerous as might be expected amongst this noteworthy group of poor women, although numbers did rise in

¹¹⁹ Smith, *Life in Early Philadelphia*, 60.

¹²⁰ On Irish servants in Philadelphia see Sharon Salinger, 'Send no more Women, Female Servants in Eighteenth Century Philadelphia', *Pennsylvania Magazine of History and Biography*, Vol. 107, No.1 (1983), 29-31.

¹²¹ Quote taken from, Dennis Clark, *The Irish in Philadelphia: Ten Generations of Urban Experience* (Philadelphia: Temple University Press, 1973), 47.

¹²² Amy Gilman, 'From Widowhood to Wickedness: The Politics of Class and Gender in New York City Private Charity, 1799-1860', *History of Education Quarterly*, Vol.24, No.1 (1984), 73.

correspondence with immigration rates. By 1810, nearly 30 percent of almshouse inmates cited their birthplace as Ireland.¹²³ However, in the same year only 15 percent of female venereal inmates were of Irish birth. This may partially substantiate Hasia Diner's claim that although 'Irish women were known for hard drinking... [yet they] rarely crossed the line when it came to sexual deviance'. She concludes that the 'numbers of Irish prostitutes remained small'.¹²⁴ Although the numbers were not as high as might be expected the almshouse data makes clear that they *were* a distinct presence.¹²⁵ Some Irish women caught disease before they even arrived in the "land of plenty," like Bridget Devlyn who was admitted to the almshouse when 'she [had] just landed in Philadelphia.'¹²⁶ Diner has been shown that illegitimacy and prostitution were relatively rare in Ireland. After working class Irish women arrived in Philadelphia, there appears to have been a breakdown in the sexual mores of their homeland.¹²⁷ This is apparent amongst many young Irish women who settled in the more libertine environment of Philadelphia. In fact, at a later date the proportion of Irish born women recorded on the almshouse's Prostitutes' Register significantly surpassed native born women.¹²⁸ The Register confirms that 35 percent of prostitutes who applied for medical relief in the almshouse were Irish, compared with 26 percent who were Philadelphia born. Therefore, I would argue against Diner's contention that Irish women rarely engaged in prostitution in America.

Like Europeans, black migrants changed the character of Philadelphia's ethnic landscape during the late eighteenth century. By the early 1800s, the burgeoning black community comprised one-tenth of Philadelphia's residents and around fourteen percent of the almshouse population.¹²⁹ As the largest city in the most progressive

¹²³ Newman, *Embodied History*, 23.

¹²⁴ Hasia Diner, *Erin's Daughters in America: Irish Immigrant Women in the Nineteenth Century* (Baltimore: John Hopkins University Press, 1983), 114. Given that Diner's time-frame is mid-nineteenth century, I would suggest her claim is flawed if the information from Philadelphia during the same period is anything to go by.

¹²⁵ I have omitted women who claimed their husband infected them in my calculations, therefore it would be a fair assumption that many did indeed engage in prostitution.

¹²⁶ Bridget Devlyn, June 1837, Dockets.

¹²⁷ Diner, *Erin's Daughters*, 114.

¹²⁸ Philadelphia Almshouse Prostitutes' Register.c.1860, PCA Hereafter cited as Register. Again, those women who were noted as catching venereal infection from their husbands were omitted. New York physician William Sanger cited 'more than half of the prostitutes' in Blackwell Prison as 'being from Ireland'. William Sanger, *The History of Prostitution: Its Extent, Causes and Effects Throughout the World* (Harper: New York, 1859), 465.

¹²⁹ Gary Nash, *Forging Freedom: the Formation of Philadelphia's Black Community, 1720-1840* (Mass: Harvard University Press, 1988), 156.

abolitionist state -and the nearest to the southern slave states- Philadelphia acted as a cultural, economic and social magnet for runaway slaves. On the one hand, the city provided the conditions for the formation of a sizeable free black community. Yet black residents lived on the economic periphery of Philadelphian society, and like newly-arrived Irish immigrants, the majority had recourse to only the most marginal labour opportunities.¹³⁰ In the face of frequent discrimination and possessing a lack of basic skills, black Philadelphians became the city's lowest wage earners. According to Priscilla Clement, even when black residents were semi-skilled, Irish immigrants often competed for the same jobs, and it was 'the Irish who usually won'.¹³¹ For black women, domestic work in laundressing was often the best that could be hoped for. Not only was this the one of the worst paid jobs, it was also one of the most physically exhausting. As Stansell points out, 'washing clothes was an onerous task that required strength and submitting to extremes of hot and cold'.¹³² We may naturally assume that black women who could hope for nothing better than laundressing were often destitute, and thus in danger of being lured into prostitution. In fact there is evidence that bawdy houses in Philadelphia catered specifically to the black population, in addition to houses assigned for interracial mixing. Like the brothel directories found in London during the eighteenth century, the pleasure-seeking man in Philadelphia could consult a similar manual, which included ethnic-specific brothels. In *A Guide to the Stranger, or Pocket Companion for the Fancy*, the author distastefully pondered why a respectable gentleman would buy the sexual services of black women when they could choose their 'fair skinned rivals'.¹³³

Given their increasing numbers and their poverty, we might reasonably expect that black or mixed-race women be over-represented in the female venereal ward of the almshouse. Yet the evidence suggests black women rarely accounted for even a

¹³⁰ It should be noted however that while blacks were mostly reduced to jobs at the lower end of the occupational scale, some of the community did succeed in material terms. For instance, in 1812, the census indicated that 11 percent owned property, which can be taken as 'a firm indication of a middle class position'. Nash, *Forging Freedom*, 214.

¹³¹ Clement, *Welfare and the Poor*, 32-3. For Philadelphia's black and Irish population competing for jobs also see, Clark, *The Irish in Philadelphia*, 18.

¹³² For a discussion of lower class black women's work see, Wilma King, *The Essence of Liberty: Free Black Women during the Slave Era* (Missouri: University of Missouri Press, 2006), 63; Christine Stansell, *City of Women, Sex and Class in New York, 1789-1860* (Illinois: University of Chicago Press, 1987), 13.

¹³³ This directory was published slightly later than the period being considered. *A Guide to the Stranger, or Pocket Companion for the Fancy Containing a List of the Gay Houses and Ladies of Pleasure in the City of Brotherly Love and Sisterly Affection*, Library Company of Philadelphia, 7.

quarter of female venereal admissions (see Table 1). While we would not expect the number of black venereal inmates to surpass the numbers of native whites, it is nevertheless surprising that the percentage of black diseased women is not higher. Moreover, as Gary Nash reminds us, the black population was crammed into the densely packed alleys of the city and they were especially concentrated in the ‘tenements and shanties of Southwark’.¹³⁴ Prostitution was endemic in Southwark and black women would have walked past brothels every day, reminding them of this economic option, if not in Southwark itself, then in other parts of the city where one might remain anonymous. In Boston, blacks appear to have been over-represented in the House of Correction records, and Hobson suggests that brothel-keeping was an attractive and popular option for black women given that they were denied access to other, more legitimate commercial ventures.¹³⁵ For those who relocated to Philadelphia after escaping slavery, the desire to remain anonymous in the bustling metropolis would have been a considerable concern. Thus the idea of being brought before a court for disturbances in brothels, or even loitering in the street, would have prevented many women from engaging in an occupation that might attract unwanted attention. James and Lois Horton have shown that while blacks and the Irish were over-represented in property crimes, ‘whites were far more likely to be arrested for crimes against the public order’ such as rioting or keeping a house of prostitution. In addition, Smith argues that the black community formed and maintained strong family ties, perhaps encouraging a culture that was less sexually permissive than that of whites.¹³⁶ In her study of New York prostitution, Hill contends that ‘black women may have avoided prostitution more than white women because they were discriminated against by clients or feared racially motivated abuse by customers’.¹³⁷ This is a valid theory if the sensibilities of our brothel directory author were shared by the Philadelphia men who frequented prostitutes.

¹³⁴ Nash, *Forging Freedom*, 248.

¹³⁵ Hobson, *Uneasy Virtue*, 44.

¹³⁶ James Oliver Wharton, Lois E. Horton, *In Hope of Liberty: Culture, Community and Protest Among Northern Free Blacks, 1700-1860* (New York: Oxford University Press, 1998), 108; Smith, *Lower Sort*, 195.

¹³⁷ Hill, *Sister's Keepers*, 56. For a discussion of racially motivated violence against Philadelphia's free black community see Theodore Hershberg, ‘Free Blacks in Antebellum Philadelphia: a Study of Ex Slaves, Free Born, and Socio-Economic Decline’, *Journal of Social History*, Vol. 5, No.2 (1971), 185.

An additional group of diseased women were those who apparently contracted venereal disease at home. Women's partners were not strangers to the brothels of Philadelphia, such as the husband of forty-year-old Maria Baird who 'keeps company with bad women'. Others, like Christina Coleman had been deserted by their husbands, yet not before they had been left 'pregnant and venereal'.¹³⁸ There were also those who contracted venereal disease while their husbands were absent, but not surprisingly the surviving records reveal little of the particular circumstances. The following cases highlight how hazy the records actually are. In 1812 Sarah Peterson, an eighteen-year-old Southwark resident turned up at the doors of the almshouse infected 'with the venereal...from her husband who has forsaken her 3 weeks ago and has gone to sea'. However, the clerk in charge of noting admissions discredited her account and 'supposed she is an impostor'. She was also recorded as an eighteen-year-old Southwark native. Catherine Williams, a diseased twenty-year-old Irish immigrant was admitted in 1811, and like Sarah she was 'willing to testify that she got the disease from her husband' who 'went to sea 3 months ago'. However, it was later discovered that she 'had come from Catherine Adams boarding House in Front Street two doors down from Nancy Yard's'.¹³⁹ Did Adams and Yard host illicit activities in their boarding houses? It is indeed possible that Catherine had in fact taken up residency in a house of ill fame in an effort to survive while her husband was away: she may have been too ashamed to admit this or she sought to avoid the judgments of almshouse officials, or perhaps she was trying to protect Catherine Adams. Certainly, it would seem that the two women in charge of the boarding houses were familiar to the almshouse clerk as brothel keepers.¹⁴⁰ For the most part brothel owners were left alone to carry on with their businesses, as illustrated by the following report in the *Public Ledger*. When the respectable gentleman James Mcleary was 'taking a walk through the city', he was invited into a 'house kept by Henrietta Queer [in] Sassafras Alley'. Here he gave the women the women inside 'one dollar to procure some liquor'. However, he complained to the mayor that 'they refused to give him any and turned him out of doors'. The mayor, on hearing his account 'told him it served him right' and immediately released the women from

¹³⁸ Maria Baird, Sep. 1801. Christina Coleman, 21 Nov. 1804, Dockets.

¹³⁹ Sarah Peterson, May 1812; Catherine Williams, 29 Oct. 1811, Dockets.

¹⁴⁰ There was an unusual surge of arrests of bawdyhouse keepers in 1810-11. According to Lyons, during this period women would not be admitted to the almshouse with venereal disease without revealing where they had been infected, that is, identify the brothel keeper. Thus, the clerk identified the boarding houses as brothels. Lyons, *Sex among the Rabble*, 343.

prison where they had been incarcerated after McLeary had accused them of robbing him.¹⁴¹ Whatever the source of Catherine William's infection, her example demonstrates the difficulty in distinguishing between women who engaged in prostitution -however casual- and those who had indeed caught the disease from their husbands or partners.¹⁴²

1.4 'a seamstress...can rarely earn enough to support herself'

A women's decision to sell her body was often triggered by economic considerations, particularly in the face of limited employment opportunities. Eighteenth century contemporaries preferred to blame bad character and the moral weakness of women as the motivating factors. However, during the nineteenth century social commentators increasingly acquired a more scientific approach by taking account of social phenomena, particularly those related to poverty and urban vice. They also turned their attention to the economic reasons behind the pervasiveness of prostitution.¹⁴³

Women were active participants in the urban wage economy in early national Philadelphia. Some -particularly single women- worked as shopkeepers, midwives and tavern keepers.¹⁴⁴ While women from the middling classes could generate a substantial income through these occupations, those from the lower sorts were not so fortunate, with the majority working as domestic servants, laundresses and seamstresses. For many working families, income rarely surpassed expenditure, and hardship consumed their lives. After the Revolution the material lives of Philadelphia's lower sort deteriorated and the city's poorest citizens struggled to earn enough money to meet the most basic of expenses in the face of exorbitant inflation.¹⁴⁵ While both sexes suffered from low wages and uncertain, seasonal employment, women suffered more. Given that a female wage was barely half that of a man's, and 'certain species of male labour afford wages barely adequate to support a

¹⁴¹ PPL, Jan. 17, 1837.

¹⁴² Later records make for easier analysis, and the early 1860's Register is a good indicator of the proportion who caught disease from their husband. This group account for 15 percent of the total number of almshouse women registered with venereal infection.

¹⁴³ Stansell, *City of Women*, pp.175-7; Hill, *Sisters Keepers*, p.46.

¹⁴⁴ For a detailed discussion on women's work in the eighteenth century see Jeanne Boydston, *Home and Work, Housework, Wages and the Ideology of Labor in the Early Republic* (Oxford: Oxford University Press, 1990) and Karin Wulf, *Not All Wives: Women of Colonial Philadelphia* (Philadelphia: University of Pennsylvania Press, 2005), ch. 4.

¹⁴⁵ For a detailed breakdown of wages and material conditions see Smith, *The Lower Sort*, ch. 4.

small family on the most economical plan', we can assume that life was certainly grim for many of Philadelphia's working class women.¹⁴⁶ Often husbands deserted their wives, while the dangerous conditions associated with seafaring and labouring left wives to deal with the consequences of a spouse's prolonged absence or premature death, as did recurring yellow fever epidemics.¹⁴⁷ If a working-class man could barely support his family on meagre wages as Smith has calculated, then the untimely loss of the breadwinner would have reduced many women to destitution. Between 1790 and 1860, 15 percent of heads of households in Philadelphia were women.¹⁴⁸ Smith has pointed to the disproportionately high numbers of women who experienced impoverishment more severely and more often than men, and twice as many women as men were dependent upon poor relief.¹⁴⁹ Mathew Carey bitterly condemned the poverty of working class women, observing that 'a large proportion of them are poor widows and women with small children'.¹⁵⁰ It therefore often followed that some widows turned to prostitution. After the death of her husband, Elizabeth Barr became a regular visitor to the almshouse being in order to secure poor relief for herself and young child. On her third admission, it was noted that Elizabeth had returned with venereal infection. Elizabeth's fate is not clear, but it is likely that her child was put in the Children's Asylum, and then bound out to service.¹⁵¹ Women in similar circumstances fill the pages of the almshouse dockets. Sarah Brooke's story is typical. In 1797 Sarah and her husband migrated from New Jersey to Philadelphia. However, Sarah's twenty-two-year old husband died, perhaps during the particularly severe yellow fever epidemic which swept Philadelphia in 1799. She subsequently 'lived at service as Maid in different families'. Sarah clearly failed to make ends meet, subsequently drawing on an alternative strategy to make ends meet by turning to prostitution, and she arrived at the almshouse in 1800 'highly venereal'.¹⁵² Life was precarious for widows like Elizabeth and Sarah, and the almshouse records reveal

¹⁴⁶ Matthew Carey, *Plea for the Poor* (Philadelphia: 1836), 5-6 and *Public Charities of Philadelphia*, (Philadelphia: 1828).

¹⁴⁷ Ten percent of the city's population succumbed to the disease during 1793.

¹⁴⁸ Priscilla Ferguson Clement, 'Nineteenth Century Welfare Policy Programs, and Poor Women: Philadelphia as a Case Study', *Feminist Studies*, Vol. 18, No.1 (1992), 35-6; Gary Nash, 'Poverty and Politics in Early American History', in ed. Smith, *Down and Out in Early America*, 11.

¹⁴⁹ Billy Smith, 'Poverty and Economic Marginality in Eighteenth Century America', *Proceedings of the American Philosophical Society*, Vol. 132, No.1 (1988), 102. Also see, Karin Wulf, 'Gender and the Political Economy, 163-88.

¹⁵⁰ Matthew Carey, *Plea for the Poor*.

¹⁵¹ Elizabeth Barr, 1 Nov 1838. For details of the Board of Guardians policy of binding out children see Lyons, *Sex among the Rabble*, 388.

¹⁵² Sarah Brooks, 22 October 1800, Dockets.

many other women in a similar situation resorting to prostitution in order to maintain a livelihood.

Records pertaining to the occupational background of diseased women are far from complete. Table 2 illustrates data taken from a rare source, listing the occupations of women who sought outpatient treatment for venereal disease at the Philadelphia Northern Dispensary, located on the fringes of the city. Evidently the majority were seamstresses, and it is possible many were -or had been- married, given that their average age (27) is way higher than that of women in the almshouse.¹⁵³

¹⁵³ 'Northern Dispensary of Philadelphia for the Medical Relief of the Poor, Register of Patients, 1816-1862' HSP. For information on the regulations of the Dispensary at the Pennsylvania Hospital when it was opened in the 1780s see *Rules of the Philadelphia Dispensary for the Medical Relief of the Poor* (1786), PHA.

	Seamstress	Service	Unknown
% of Total	63	27	10
	n=14	n=6	n=2

Table 2: Occupation of Dispensary Venereal Patients, 1816-1817, Source: Northern Dispensary Registry of Patients, 1816-1817, HSP.

Philanthropist Matthew Carey calculated the cost of living against basic wages, and found that, whether skilled or not, the average seamstress made on average around \$1.15 weekly.¹⁵⁴ He suggested that rent ‘absorbed two-thirds of their earnings’ before food and fuel were even accounted for.¹⁵⁵ Carey concluded that a Philadelphia ‘seamstress or spooler can rarely earn enough to support herself...if she does not steal or prostitute herself to make up the balance, she is reduced to applying for charity relief’. He lamented that even an ‘expert women unencumbered with families and with steady employment cannot average more than a dollar...a week’ working as a seamstress.¹⁵⁶ For instance, Elizabeth Frazier’s husband ‘was committed to jail for up to five years’, after which, Elizabeth worked as a seamstress in order to make ends meet with a slightly above average ‘earning [of] \$1.50 per week wages’. Her husband’s imprisonments, coupled with the long hours and low wages associated with seamstress work, contributed to her declining physical and mental health. Life must have been a hard struggle for Elizabeth Frazier, and she was admitted to the almshouse in 1811 ‘in a state of mental illness owing to her taking a great quantity of Laudanum’.¹⁵⁷

The almshouse records also make clear that a large number did, or had worked as servants. During the second half of the eighteenth century, as Lyons points out,

¹⁵⁴ Carey calculated that an expert seamstress who worked industriously from morning till night (not accounting for illness) could not make more than two shirts a day, of which each shirt earned her around 10 cents. A widow with small children would average about seven weekly, thereby reducing the already pitiful wages. A single woman employed as a seamstress Carey calculated only just earned the minimal annual cost of rent, food, clothes, fuel and candles. See, Matthew Carey, *Plea for the Poor* (Philadelphia, 1836), 5-6; *Public Charities of Philadelphia*, (Philadelphia, 1828), 167.

¹⁵⁵ According to Marilyn Hill, in New York, the poorest accommodation often amounted to \$1.50 weekly. Hill, *Their Sisters Keepers*, 85.

¹⁵⁶ Matthew Carey, *Report on Female Wages* (Philadelphia, 1829), 268.

¹⁵⁷ Elizabeth Frazier, 18 Apr. 1811, Dockets.

‘demand for paid domestic labour was...driven by rising standards of domestic comfort and display, fuelled by growing consumerism’, and thus ‘opportunities in domestic service increased dramatically’.¹⁵⁸ Wulf suggests that servants were hired in Philadelphia not only in the most affluent households but also in the homes of the middling sorts. She asserts that 38 percent of households in the middle-class Chestnut Ward hired white domestic servants. Numerous young women travelled from the countryside in search of domestic employment in the urban metropolis, as did the many black women, both slave and free. Yet, like seamstress work, domestic service was badly paid, despite often providing the ‘security of room and board’.¹⁵⁹ As Alice Harris notes, the average servant’s wage only just covered basic survival.¹⁶⁰ A large number of black women also entered domestic service. According to Nash, many recently freed slaves ‘returned to the limbo between slavery and freedom...consigning themselves and their children to servitude’. Thus, servitude was not a ‘promising world of opportunity’, but rather ‘servants were treated little better than chattel’, often being left in a more impoverished condition than they started.¹⁶¹ Indentured servitude was disappearing in Philadelphia by the end of the eighteenth century. However, as the urban mercantile marketplace transformed into a laissez-faire economy, waged domestic work promised a production system just as exploitative and uncertain, with masters preferring to hire and fire the cheapest workers available. Yet, as Nash explains, this was indeed one of the best opportunities available to blacks seeking to build a more stable future.¹⁶²

Available almshouse data on the demographic and occupational background of diseased women suggests a significant number of those drawn from the servant class were young country girls, either restless and in need of adventure in a bustling seaport culture, or indeed attempting to escape rural poverty. In 1811 for instance (when there is more complete information) 34 percent of diseased women drawn from the servant class, had moved to the city from the Pennsylvania counties, outnumbering those from Philadelphia itself.¹⁶³ Sarah Harding for instance arrived in Philadelphia from the Pennsylvania countryside, and during the four years she had worked in the city, she

¹⁵⁸ Lyons, *Sex among the Rabble*, 31.

¹⁵⁹ Wulf, *Not All Wives*, 136, 142.

¹⁶⁰ Harris, *Out to Work*, 8.

¹⁶¹ Salinger, ‘Send no more Women’, 30.

¹⁶² Nash, *Forging Freedom*, 79.

¹⁶³ Dockets, Almshouse Weekly Census and Admissions, 1811

‘lived with several families [as domestic] but [was] not more than nine months in the employment of any one person’.¹⁶⁴

Birthplace	Percentage of Servant Admissions (n=21)
Philadelphia	28
Other Pennsylvania	34
Other USA	19
Europe	10
Unknown	9

Table 3: Birthplace of Female Servants Admitted to Almshouse Venereal, 1811, Source: Philadelphia Almshouse Female Receiving Register, Daily Occurrence Dockets; PCA.

Others had grown up in an urban environment but were eager to escape parental ties. Sarah Caswell arrived in New York with her parents as a child from England. In 1806, she left her family behind and moved to Philadelphia to try her hand at domestic service. When she arrived for venereal treatment at the almshouse five years later, the clerk noted, she has not ‘lasted more than twelve months in any one place’ of service.¹⁶⁵ The almshouse data implies that a number of servants contracted disease whilst at their place of service.

Sexual danger was rife in domestic service and servants turned up at the almshouse both venereal and pregnant, with their masters occasionally paying for their board.¹⁶⁶ Since masters could, and often did fire women who became pregnant or were unable to work, such apparent kindness may have been inspired by responsibility and guilt. Illicit pregnancy constituted a major problem in revolutionary Philadelphia and pre-marital pregnancy rates were significantly higher amongst the lower classes.¹⁶⁷ Historians have established relatively high pregnancy rates among female domestic servants. For instance, Ann Griffith was admitted to the almshouse in 1806, with the

¹⁶⁴ Sarah Harding, 25 Nov. 1808, Dockets.

¹⁶⁵ Sarah Caswell, Feb. 1811, Dockets.

¹⁶⁶ For some examples see, Nov. 1791, Jan. 1792, 20 Sep. 1804, 20 May 1811, June 1837, Dockets.

¹⁶⁷ Susan Klepp, *Philadelphia in Transition, A Demographic History of the City and its Occupational Groups, 1720-1830* (Philadelphia: Garland, 1990), 88-92.

clerk noting that 'she is pregnant and has sworn her pregnancy before the Mayor against Richard Eyres, a servant in the same house'.¹⁶⁸

Boredom may have led domestic servants towards the exciting environment of the seaport's nightlife after a day's work, and consequently, towards its temptations to earn extra money to supplement a meagre income. A contemporary was struck by the numbers of servants who,

...love to dress up for the evening promenade, which lasts from nine until eleven and, it's said, leads them to places where they traffic their charms. At the slightest whim they leave the house where they serve, sometimes in the middle of a meal [and] they get drunk.¹⁶⁹

Elizabeth Drinker despaired of her servants' autonomous nocturnal activities, bemoaning that Sally Dawson 'did not come home till midnight'. Dawson's sexual behaviour alarmed the pious Quaker, who also complained that Sally 'ha[d] a beaux after her'.¹⁷⁰ Philadelphia's sexually permissive culture may also have acted as a magnet for domestic servant Amelia Wheeler. She relocated to Philadelphia from New Jersey in the early 1790s after she had 'served her time'. Before long she had succumbed to the apparent lucrative opportunities offered by prostitution, but she often landed in trouble with the local watch. The records reveal that on at least four occasions, she was picked up by the constables. On one occasion, Amelia was 'taken at midnight' along with a crowd of other youths. On another occasion when she was taken into custody she was noted as 'an abandoned prostitute'. Amelia paid the price for her dreams of the city, when drink and venereal disease soon overtook her life.¹⁷¹ The flexible working hours and higher wages afforded by the sale of sexual services proved an attractive option to those working class women employed in underpaid, exploitative work.

¹⁶⁸ Ann Griffith, 16 Aug. 1806, Dockets. All women who became pregnant from an illicit encounter seeking almshouse relief were obliged to swear the identity of the father before the mayor's court, unless the father had already posted bond (secured the maintenance of the child). According to Lyons, while non-marital sex was not punishable, if a woman became pregnant the law carefully monitored such bastardy cases. She claims 'the Overseers role was to regulate child support, not to punish the sexual behaviour of the parents'. Lyons, *Sex Among the Rabble*, 77.

¹⁶⁹ Kenneth Roberts and Anna M. Roberts (eds), *Moreau de St. Mery's American Journey, 1793-1798* (Garden City: New York, 1947), 297-8.

¹⁷⁰ Elaine Forman Craine, *The Diary of Elizabeth Drinker Diary* (Boston: Northeastern University Press), 12 March 1803.

¹⁷¹ Amelia Wheeler, May, Aug 1793, Dockets; 19 Jun 1795, 29, July 1796, Sep. 1796, Vagrancy.

1.5 'the second time he gave me \$2'

It is not clear how much women earned from the sale of sex. Moreau de St. Mery suggested in 1793 that 'they fulfil every desire for two dollars half of which is supposed to pay for the use of the room'.¹⁷² If he was referring to a house of assignation where prostitutes rented by the hour, then the money to be made in sexual services was indeed profitable, and therefore an attractive supplement -or alternative- to the wages of a domestic servant. A report in the *Public Ledger* thirty years later substantiates the French traveller's claims. Brought before the Quarter Sessions Court of Oyer and Terminer for a 'case of bastardy', unmarried Harriet Sperry claimed that she was 'the mother of the child', who was the result of a liaison at 'a ball in Callowhill Street'. According to eighteen-year-old Mary,

We walked as far as Mrs. King's boarding house in Seventh Street, between Pine and Spruce...t'was there where the child was got...We staid in there about one hour and I saw him about a week afterwards in the same house...the second time he gave me about \$2...the third time he gave me about \$2.¹⁷³

It would be safe to assume that Mrs. King owned a boarding house, not necessarily a brothel. As Harriet claimed, 'I did not know what kind of house he took me into' but 'after the door was locked I found out to my sorrow'. The young woman 'followed plain sewing...working for a tailor in Market Street', and she clearly found the extra income earned by her illicit encounters attractive. She 'met him again all at the same house...three or four times'.¹⁷⁴ If she had lived in a brothel or boarding house, Harriet would have profited handsomely, even after the madam received her share. From Harriett's experience we can deduce that the income for women who engaged in casual prostitution was around \$2 an hour. Carlisle suggests, 'prostitutes were the best paid women workers, even if they only worked three days a week'.¹⁷⁵ Yet there were certainly various factors that would affect the price: age, attractiveness, race, ethnicity and her health. Evidence from the mid-nineteenth century almshouse Prostitutes' Register reveals that servants were paid on average from \$1.25 to \$1.50 weekly. Therefore, the economic benefits reaped from sexual encounters indicate prostitution was highly profitable in a city marked by frequent impoverishment amongst lower

¹⁷² Roberts, *American Journey*, 313.

¹⁷³ PPL 14 December, 1837.

¹⁷⁴ Ibid.

¹⁷⁵ One Philadelphia historian suggests, 'Some houses charged two dollars per visit. Other prostitutes would have received more'. Carlisle, 'Prostitutes and their Reformers', 36.

class women. Moreover, a woman could enter prostitution easily, and this to many would have served as a major enticement. Previous experience, training and references were not required, and a young girl could visit any one of Philadelphia's numerous haunts of prostitution to solicit custom.

Given the paucity of detail in the records, we have little way of knowing how prostitutes actually felt about their lives and work. Therefore, it is impossible to give a definitive answer as to why they made the decision to engage in prostitution in the first place. According to Wulf 'prostitution must have been a last resort'.¹⁷⁶ This may have been true for some women, and while many would have found the choice a difficult one, as we shall see in chapter three numerous prostitutes showed little signs of feeling degraded by the nature of their occupation. Thus, it is likely some treated the sale of one's body as just another way of getting by in a precarious economic climate. While there has always been a social stigma attached to prostitution, working class women of the late eighteenth and early nineteenth centuries may not have perceived it as particularly shameful.¹⁷⁷ Thus, we should bear in mind that a women's decision to sell her body, by whatever means, may not have been as difficult a decision as it would be for the modern woman. Furthermore, it would appear prostitutes living in early national Philadelphia often shared the same public spaces with Philadelphia's better sorts. Prostitutes appear to have been perfectly at ease coming forward to use the courts to settle grievances and obtain redress in the same manner as Philadelphia's more "respectable" citizens. According to Lyons,

Bawdyhouses were not places for secret, anonymous sex, but social places where individuals encountered friends and associates...Even some wives were familiar with the bawdyhouses used by their husbands and sometimes retrieved them from the premises. Prostitution under these circumstances was a very social event...[operating] in many of the same social spaces as other forms of non-marital sex...As such, prostitution was mixed up with the social and sexual activities of those engaging in non-commercial sexual ventures.¹⁷⁸

¹⁷⁶ Wulf, *Not All Wives*, 142.

¹⁷⁷ Stansell, *City of Women*, 191.

¹⁷⁸ Lyons, *Sex Among the Rabble*, 280-81. For a discussion on using court records to explain prostitutes' freedom in the city see Carlisle, 'Disorderly Women', 554-65.

Prostitutes were not treated as outcasts, although they were increasingly marginalised over the course of the nineteenth century. In fact they appear to have been integrated throughout the neighbourhoods and social venues of early national Philadelphia.

1.6 The Brothel and the Streets: prostitutes' work

Women worked as prostitutes in the brothels, theatres and streets of Philadelphia. Contemporary accounts confirm the multitude of environments catering for the sale of sexual services. Unlike Boston and New York, where brothels and houses of assignation were clustered in specific districts, sexual commerce in Philadelphia was dispersed throughout the city in mixed neighbourhoods of rich and poor and black and white.¹⁷⁹ According to Carlisle, until the mid-nineteenth century 'the wards of Philadelphia were a disorderly mixture of rich, middling and poor' with 'little room for privacy, no premium on decorum'. As noted, prostitutes were a familiar part of this landscape, 'moving freely and openly on the streets and places of amusement'.¹⁸⁰ Therefore, a woman could easily find work in the city's streets, parks, dance and gaming houses, oyster bars, taverns and tippling houses. In his journal, Moreau de St. Mery commented on 'the frequent houses of ill fame, which have multiplied in Philadelphia'.¹⁸¹ Almshouse inmates were often very familiar with these brothels. In 1793 Ann Brown was admitted for venereal treatment after being 'brought from a bawdy house in Southwark'.¹⁸² Southwark harboured many such 'lewd houses'.¹⁸³

¹⁷⁹ On Boston see Hobson, *Uneasy Virtue*; On New York see, Gilfolye, *City of Eros*, and Hill, *Sisters Keepers*. Moreau de St. Mery also visited New York, and explained that he found brothels arranged in clusters in what we would now call red-light districts. 'In many parts of the city' he explained, 'whole sections of streets are given over to street walkers...many houses of debauchery in a locality.' Roberts, *American Journey*, 156.

¹⁸⁰ Carlisle, 'Disorderly Women', 549.

¹⁸¹ Roberts, *American Journey*, 312. Despite having lived in the sexually liberal communities of Paris and Saint Domingue, the Frenchman was quite taken aback by Philadelphia's permissive climate. Also see Lyons, *Sex Among the Rabble*.

¹⁸² Ann Brown, Jan. 1793, Dockets.

¹⁸³ While brothel arrests in Philadelphia were sporadic and minimal, the sex commerce trade did upset some citizens of Southwark. Taking the law into their own hands, they managed to close down a brothel in the area known as the China Factory. See Claypoole's *American Daily Advertiser* (Philadelphia,) Aug. 1800. Lyons suggests, 'that Philadelphia had few such riots...indicates prostitution was secure'. Lyons, *Sex among the Rabble*, 341

Many almshouse women did indeed work in the brothels.¹⁸⁴ For a short period, almshouse authorities tried to force venereal women to admit where they had caught disease before being permitted to enter the venereal ward. Between 1811 and 1812 for example, 25 percent of women admitted into the almshouse with venereal infection declared that they had been working in a brothel.¹⁸⁵ In January 1812, Harriett McCoombs was admitted to the ward, claiming ‘she took the disease at a Bawdy House in Shippen Street [Southwark] ...kept by Eliza Aldberger’. In the same month Elizabeth Saunders was willing to ‘qualify that she got it at the house of Ann Williams a place of ill fame [and] she lived in the said house about 2 months’. A few weeks later Elizabeth Carr was admitted and disclosed that she had contracted disease by working at the same house as Harriet.¹⁸⁶

A wide array of brothels was available to Philadelphia’s prostitutes. Historians of prostitution contend that sex commerce did not have a significant presence in early national American cities such as Boston and New York. Lyons argues that ‘Philadelphia could not have been more different’,

...there were bawdyhouses on the city’s main streets and more modest establishments among its alleys. Sex commerce also took place in the backrooms of taverns...and often spilled out into the streets...then retiring to rented rooms or bawdyhouses.¹⁸⁷

An implicit hierarchical stratification characterised prostitution, with discernable “classes” of prostitutes.¹⁸⁸ There were lowly, unmarried fallen woman who were seen by civic authorities and reformers as being in need of rescuing; desperate married or widowed women in need of temporary funds; professional streetwalkers and women in brothels. Moreover, what constituted the upper class brothel experience differed markedly from that of the brothels of a lower class, which were frequented by impoverished prostitutes. While we can only speculate, it is likely the majority of almshouse prostitutes drew their clients from the working classes; certainly women of

¹⁸⁴ Ruth Rosen has uncovered evidence suggesting that roughly half of 3,311 Philadelphia prostitutes interviewed during the Progressvie Era admitted to either residing in, or working in brothel establishments. Rosen, *Lost Sisterhood*, 86.

¹⁸⁵ Dockets, Oct. 1811 to Jun. 1812.

¹⁸⁶ Harriet McCoombs, 12 Jan 1812; Elizabeth Saunders 7 Jan. 1812; Elizabeth Carr, Feb. 1812, Dockets.

¹⁸⁷ Lyons, *Sex Among the Rabble*, 279.

¹⁸⁸ For a detailed discussion on the existence of a prostitution hierarchy or ‘whorearchy’ see Gilfoyle, *City of Eros*, ch. 3.

the immigrant lower sorts would be more likely to have attracted patrons of a similar social standing. Women from specific ethnic groups who preferred to solicit custom from their own class could easily find such an environment. For instance, Maria Ramsey kept a ‘house of rendezvous’ by the wharves of the Schuylkill, which ‘catered for *coloured* boatsmen’, in addition to her ‘headquarters for coalheavers’.¹⁸⁹ A mid-century New York physician claimed that Irish prostitutes were patronized by ‘the lowest class of visitors of the lowest order of rowdies’ who ‘clustered round the liquor stores in low neighbourhoods...a great number of foreign born women are found in this class’. He explained that ‘the principal part of the women are of Irish heritage’.¹⁹⁰ Given the existence of anti-Irish sentiments in Philadelphia, prostitutes with such roots suffered similar discrimination to black women, and would therefore have sought and attracted clients of their own kind.

However there were exceptions to the rule. Prostitution has always been marked by fluidity, not only for the ease of which a woman could move in and out of it. The hierarchy was exceptionally unstable; one minute a woman may have been cutting a dash in the more elegant brothels of Philadelphia, the next, struggling to drum up business among labourers and seamen in the back of one of the city’s numerous waterfront dram shops and oyster bars.¹⁹¹ Many white, native-born almshouse prostitutes would have started their career in sexual commerce nearer the top end of the sexual marketplace. Furthermore, a prostitute of the lower sort was not necessarily restricted by her social status in attracting rich clientele, and there was a mixing of classes within these establishments. A contemporary writer bemoaned that ‘houses of prostitution [are] allowed in large cities, for the accommodation of sailors, strangers and wealthy idlers’.¹⁹² A lower class woman could indeed have attracted clients drawn from the better sort, with the potential of making a profitable wage. An anonymous writer to the *Pennsylvania Public Ledger* complained about the ‘numerous private and public houses where the youth of both sexes in the evening meet for...dancing and drinking’. He further noted that ‘they are visited by men of the

¹⁸⁹ PPL, 20 Oct. 1837.

¹⁹⁰ Sanger, *History of Prostitution*, 565-7.

¹⁹¹ This would certainly be the case for those who started in elite prostitution yet became visibly marked with disease and therefore unable to find work in a classier establishment. Thus, they would have been forced to go “down market”.

¹⁹² John A. Beck, *Inaugural Dissertation on Infanticide* (College of Physicians: New York, 1817), 4.

first respectability and by the daughters of the poor”.¹⁹³ A series of letters between William Chew (the son of one of Philadelphia’s leading families) and his friend William Shepherd is also illustrative. Both men clearly found themselves in trouble with women on a regular basis given that they often cavorted around the brothels and taverns of the city. Shepherd indicates that he visited prostitutes on a regular basis, lamenting that ‘with lewd women we satisfy the beastly part of our nature’. He wrote to Chew about an experience he had with a prostitute he believed had given him ‘the most violent clap’. He claimed that ‘I was content with a less delicate one [prostitute] and paid dearly for it’. That he paid for sex with ‘a less delicate one’ suggests that he had an encounter with a lower class prostitute.¹⁹⁴

It would be a reasonable assumption that diseased almshouse women were not solely drawn from the lower sorts. Prostitution was an occupation that included some women from the more respectable circles of society. According to Moreau de St. Mery the ‘daughters of Quakers are frequent visitors to the houses of ill fame’.¹⁹⁵ The following example may have reflected the lives of many other young girls who were drawn from the wealthier classes, eager to escape familial restraints yet only to find they would end their days in the almshouse. The *Public Ledger* carried a report about a young Philadelphia girl whose mother lived in ‘moderate circumstances...a character which many who flaunt in silk might well be proud of’. The woman’s unnamed daughter ‘who is but 16 years of age deserted her mothers protection and went to a house of ill fame kept by Elizabeth Swipes, in Sassafras Alley’. Life here, in the northern outskirts of the city, could indeed be grim. This was noted in the *Public Ledger* by ‘a correspondent [who] informs us that the steps above *Sassafras* street, or as it is called in our *spoken* language *Race* street...are covered with dead cats and other things of similar character’.¹⁹⁶ As one historian notes, this neighbourhood hosted a ‘rich tavern culture’ where working men gathered to ‘drink...gamble...box [and] support cockfighting’.¹⁹⁷ This young unnamed girl from respectable society might

¹⁹³ PPL, May 8, 1837.

¹⁹⁴ Chew Family Papers, Box 150, Folder ‘Correspondence and General Papers, Jan- March 1820’, (William Chew), 2 Oct. 1820, HSP.

¹⁹⁵ 19 Oct. 1837 PPL; Roberts, *American Journey*, 312. Although we should bear in mind that not all Quakers were wealthy or middle class, some were indeed poor.

¹⁹⁶ Jun. 1837, PPL.

¹⁹⁷ A. Kristen Foster, *Moral Visions and Material Ambitions, Philadelphia Struggles to Define the Republic, 1776- 1836* (Oxford: Lexington Books, 2004), 16.

have been vulnerable to taunts from unfamiliar young men and women, and even violence. Gangs of youths were regularly picked up here by the city watch for drunk and disorderly behaviour.

According to physician William Sanger, 'many...women of this rank made their debut in first-class houses, but left them when their charms began to fade'.¹⁹⁸ This would be especially so for the older prostitute or those who had lost their beauty. Disease and alcohol ravaged the bodies of many women, even those in their early twenties who had begun their careers as youngsters. As Sanger noted,

...tonight you may see her glittering at one of the fashionable theatres, tomorrow she will be found in one of the infamous resorts which abound in the lower part of the city...today she may associate with the wealthy of the land; tomorrow none will be too low for her company...today she may have servants to do her bidding; tomorrow she may be buried in a pauper's coffin.¹⁹⁹

Therefore, however a women conducted her business -and from whatever class she originally hailed- once she was in a visible state of infection, it would have been nearly impossible to procure employment, whether as a domestic servant, seamstress or even in one of the better brothels. Even if she worked in a higher grade establishment, once diseased it was likely the brothel owner would force her out, unless she paid for a physician (or sought treatment elsewhere) to temporarily cure her condition and eradicate the symptoms. Many brothel keepers did not allow drunken prostitutes in their establishments. Such a practice was not good for business and prostitutes with venereal infection were a liability. A significant number of almshouse prostitutes had clearly been suffering the effects of alcoholism and venereal disease for some time, also unable to find a way to make ends meet. For instance, in 1803 Sarah Burton was discharged from the almshouse after a spell of treatment for venereal disease 'to look for a place at service'. However, she was unable to secure work and returned only a couple of months later. The implications for some women could be severe. Maria Hall's fate is suggestive of this. Twenty-six years old and of German descent, she was deserted by her husband who left for Charleston in 1802. Maria was 'turned out of a House of Ill Fame in Cherry Street between 9th and 10th Streets' for being infected with venereal disease. After being

¹⁹⁸ Sanger, *History of Prostitution*, 453.

¹⁹⁹ Ibid.

expelled Maria spent the night wandering the streets of the city. She may have unsuccessfully attempted to find work in another brothel, and she ‘slept in the open air’. This would have made for a grim experience, Cherry Street being located in the Sassafras area of the city. The following day she walked a good distance, ‘wandering about the lots near Schuylkill’, where ‘she was found lying in a lot almost speechless...from which situation she was removed’ to the almshouse. Maria died soon after arrival.²⁰⁰ Similarly, Elizabeth Deford ‘was exposed to a street lodging in the night, not having the wherewithal to lay her head’. Elizabeth was almost deprived of ‘the use of [her] limbs’ being in an advanced state of venereal infection and later dying from the disease.²⁰¹ Women like Elizabeth paid a high price for entering into the world of sexual commerce.

1.7 “encouraging Eliza into prostitution”

Prostitutes in the almshouse were familiar with each other. The sources demonstrate the existence of a distinct prostitute culture outside the almshouse. Entry into a brothel was often at the enticement of friends. One contemporary observed the

...crowds of painted prostitutes [who] exhibit themselves...in the heart of Philadelphia mingling with the youths of our city who are thus furnished with a speedy introduction to the haunts of debauchery...where the wives and daughters of the citizens of our city are assembled.²⁰²

For example, Eliza Ross was picked up in the street by the constables for disorderly behaviour, and as ‘a young dissolute girl [and] prostitute’. Her companion Martha Toppins was also arrested for being disorderly and ‘encouraging Eliza into prostitution’.²⁰³ The paucity of evidence, coupled with the fact that prostitution existed as a clandestine occupation makes any attempt at quantifying how many women actually worked in brothels virtually impossible. That many almshouse women solicited custom quite openly in the streets with a view to taking customers to a brothel is clear from the Vagrancy Dockets, with the same women showing up in both sets of records. Mary Archer was often arrested by the city constables for ‘lewd’

²⁰⁰ Maria Hall, 21 July 1804. Dockets.

²⁰¹ Elizabeth Deford, Apr., Aug. and Sep, 1800, Dockets; Philadelphia Almshouse Weekly Return of Patients in Sick and Surgical Wards, PCA.

²⁰² An Enquiry into the Condition and Influence of the Brothels in Connection with the Theatres of Philadelphia (Philadelphia, 1834), 5.

²⁰³ Eliza Ross and Martha Toppins, 2 July 1794, Vagrancy.

behaviour on the streets, being noted as a woman who ‘frequents houses of ill fame’. Her ‘accomplice’ Judith Spratt likewise came to the attention of the city watch as ‘a lewd, drunken disorderly woman’. Others may have simply conducted their business on the streets along with fellow prostitutes. Mary Baker ‘was taken by the city watch at 10pm’ for ‘lewd’ behaviour whilst loitering in the streets along with Hannah Bond, a known prostitute. Catherine Cornish was one of a group of girls picked up for ‘soliciting in the streets’ as was Rebecca Williams who, with her friends were arrested, for ‘...strolling the streets at a late hour’.²⁰⁴ All of these women were treated in the almshouse for venereal disease. It is evident that a social network existed amongst Philadelphia’s prostitutes, one based on friendship and kinship. In the mid-nineteenth century women admitted for venereal treatment were interviewed by the Overseers of the Poor and later recorded on the Prostitutes Register. When asked why they had commenced a life of prostitution, nearly 30 percent cited ‘bad company’ as the incentive. One woman claimed she ‘got drunk at my sister’s house...and went to boarding on the town’.

Moreau de St. Mery passed remark in his journal on the communities of prostitutes visible throughout the city, observing,

...the streetwalkers of a new sort in Philadelphia...young and very pretty girls, elegantly dressed, who promenade two by two...at an hour which indicates they aren’t just out for a stroll most commonly on the south side of Market Street...anyone who accosts them is taken to their home.²⁰⁵

Networks were also formed while working at service. Margaret Barnes, a nineteen year old domestic servant turned up at the almshouse with venereal disease in 1811. She lived with ‘W. Macdonald in German Street between 4th and Plumb Streets’.²⁰⁶ Had Margaret found a more attractive economic enticement than domestic service at Julian Nixon or Nancy Green’s brothels in the same neighbourhood?²⁰⁷ Perhaps she walked the promenades alongside Sarah Thompson who we encountered earlier

²⁰⁴ Mary Archer, 22 Jan. 1794, 16 Sep. 1795; Judith Spratt, 22 January 1794, 2 Aug. 1796; Mary Baker, 19 Sep. 1792, 25 Mar. 1794; Hannah Bond, 24 March 1794, 4 Aug. 1794; 2 Nov. 1795, Margaret Brady 22 July 1793; Margaret Button 1794; Mary Carlisle 1790, 22 July 1793, 24 March 1794, 4 August 1795; Catherine Cornish 28 Feb. 1794; Rebecca Williams, 6 Oct. 1795, 1 Oct. 1796, Vagrancy.

²⁰⁵ Roberts, *American Journey*, 313

²⁰⁶ Margaret Barnes, 22 Mar. 1811, Dockets.

²⁰⁷ We might also argue that Margaret was infected by her master or partner and we can only speculate that she was a prostitute.

working in Hannah Hughes' brothel in Plumb Street. Here, the girls may have picked up some custom to take back to Hughes' 'house of ill fame'. The records bear witness to a multitude of women in similar situations to Margaret and Sarah, who contracted venereal disease while also working at service. Both women may have encountered Kitty Hadle, a twenty-nine year old former domestic woman who was brought to the almshouse with venereal disease from a brothel 'in Plumb Street, a few doors below 4th street'.²⁰⁸

Communities of prostitutes were most visible to the public when they converged in Philadelphia's theatres. The notorious third-tier was an 'understood theatrical appendage', and by the 1850s 'an established national tradition'.²⁰⁹ While higher class prostitutes sat throughout the theatre with pre-arranged custom, lower class prostitutes were relegated to the third-tier, making contact with clients inside the theatre itself. Located in the upper part of the house out of view of Philadelphia's theatre-going middling sort, the third-tier included a bar, 'contributing to the rowdy behaviour which was a constant disturbance to the rest of the theatre'. Prostitution in this environment made the American theatre the 'house of the harlot' as many streetwalkers completed their business transaction there.²¹⁰ As we shall see later, networks of prostitutes formed in the theatres, brothels and streets of Philadelphia would re-emerge inside the almshouse venereal ward. This would also suggest that individual diseased women requiring public medical relief were not always without resources and support.

This chapter has considered the lives and material circumstances of prostitutes before arriving at the almshouse as venereal patients. While we often assume from contemporary seduction tales and the historiography that women moved into prostitution as the result of a pre-marital sexual encounters, the almshouse data makes clear that impoverishment and the conditions of domestic work were also principal motivating factors. A significant number of inmates were recent immigrants, while many other women had been born and raised in Philadelphia while others had

²⁰⁸ Kitty Hadle, Oct. 29, 1811, Dockets.

²⁰⁹ Claudia Johnson, 'That Guilty Third Tier: Prostitution in Nineteenth Century American Theatres', *American Quarterly*, Vol. 27, No.5 (1975), 577.

²¹⁰ Ibid. 579.

migrated from nearby states. Some were widowed and others claimed desertion by their husbands. Many had been left with young children under their care. Others came to the attention of the city watch as they walked the streets and alleyways of the more notorious sections of the city in an attempt to ply their trade. A significant number of almshouse women lived their days in and out of Philadelphia's various "corrective" institutions, often ending up in the city jail or the Magdalen Asylum. Individual experiences varied, yet collectively once in a visible state of infection, the majority of diseased almshouse women would share very similar daily challenges.

Chapter Two

Our Extended Family: the view from above

On 12 May 1800 four Philadelphian gentlemen who sat on the board of managers at the Philadelphia Almshouse met for their weekly meeting. As was usual, the Visiting Committee's report was read aloud, as was the Treasurer's, and then the accounts were 'examined and passed'. So far, the meeting seemed routine. However, before adjourning, there was a serious matter to be discussed, for the almshouse steward John Cummings and his methods of record-keeping had come to the attention of the managers. As the Managers' Minutes reveal, 'the board observing with Concern, the many Improper...expressions in the Minutes of the Daily Occurrences [that] are filled with irrelevant matters'.²¹¹ The steward's subjective and gratuitous notations embedded within his admission and discharge notes had alarmed the managers. In particular, Cummings' pejorative comments about inmates suffering from venereal disease filled the official records to the evident displeasure of the managers of the institution. The steward's Daily Occurrence Dockets reveal a steady flow of venereal admissions, and John Cummings had gone to considerable lengths to narrate his perception of their characters and lives. For instance, when Mary Conkling sought medical relief Cummings sharply remarked, that 'this Chambermaid at the City Tavern says She has a bad sore leg...doubtless as she could daily make up beds, she might occasionally un-make one'. Cummings employed a host of derogatory terms to depict women seeking medical attention for the effects of venereal infection. Catherine Bachus was a 'saucy black wench', Ann Hoffner a 'vile Strumpet' and Mary Stroud was simply a 'strap[p]ing Prostitute'. Mary Allen was 'choice stuff' and Martha Peters, although broken down and 'very far advanced in the venereal disease' was, according to Cummings, a 'one eyed Bruiser'.²¹²

²¹¹ 12 May 1800, Guardians of the Poor, Managers Minutes, 1788-1828, PCA. Hereafter cited as M.M.

²¹² Mary Conkling, 2 Jan., 1792; Catherine Bachus, June 1796; Ann Hoffner Dec. 1789; Mary Stroud, Jan. 1789; Mary Allen, Jan. 1792; Martha Peters, 23 July 1794, Dockets. Historians have previously mistaken the author of the Dockets as being a clerk, identified by Newman as Joseph Marsh Jnr. Marsh was in fact a merchant who sat on the board of managers for a brief period and often made coal purchases for the institution. His father Joseph Marsh Snr. was an alderman. See Richard Godbeer, *Sexual Revolution in Early America* (Baltimore: John Hopkins University Press, 2002), 317; Simon P. Newman, *Embodied History: The Lives of the Poor in Early Philadelphia* (Philadelphia: University of Pennsylvania Press, 2003), ch.1; Billy G. Smith, *Life in Early Philadelphia: Documents from the*

Prior to this meeting Cummings had been ordered by the managers to,

Lay before the Board every Monday a list of all persons admitted the previous week together with their Orders of Admission and all other information respecting their places of Residence in his power to collect...after which it will be the Duty of the Attending Committee to attend to such cases & to either return them to the Overseers or dispose of them in such manner...most suitable, provided they should prove to be Non Residents.²¹³

The steward could not produce the information required of him, and at a meeting the following week it was noted that ‘the great increase in duties performed by the Steward make it impossible for him to attend to the Records of this institution’. This was not the end of the matter however, and at some point during the next twelve months, the managers seem to have come across the steward’s ledgers. Consequently, Cummings was brought to account for years of crude record keeping. Thus, at the meeting we began with in May 1800, it was ‘resolved that the steward be directed in future to have the daily Minutes kept in a plain and decent style, recording only such facts and circumstances as are necessary for the information of the managers’. John Cummings was even ordered to destroy some of his entries and recopy them.²¹⁴

Interestingly, when the Managers’ Minutes are cross-referenced with the Daily Occurrence Dockets, the volumes of Cummings’ Dockets between July 1799 and January 1800 are missing. The huge ledgers, which now lie in Philadelphia City Archives otherwise appear complete from the 1760s throughout the history of the Philadelphia Almshouse, later the Philadelphia General Hospital. The volumes may well be missing as the result of the steward’s practice of record-keeping. From the late 1780s until June 1799 (when the steward recorded the information) the huge volumes are more qualitative in nature and resemble personal journal records. Cummings’ Dockets include all sorts of information from patient particulars, cost accounts and even observations about the weather. They also present heavily anecdotal character

Revolutionary and Early National Periods (Philadelphia: Pennsylvania State University Press, 1995), ch.2.

²¹³ 17 Jun. 1799, M.M.

²¹⁴ It is possible that the managers knew nothing of the other volumes, and were only aware of those that are now missing. It is interesting to note that between March and June 1800, several of the Docket entries have been scored out, some partially and others completely. Of those still legible it is evident many pertained to venereal inmates.

references for venereal patients. After the fateful Manager's Meeting in 1800 the Daily Occurrence Dockets are recorded in a more professional style, providing biographical information about inmates in an increasingly statistical and objective nature.²¹⁵

John Cummings played a vital role in the story of diseased almshouse women. As steward, his job encompassed a whole range of duties throughout the house. He was also a prospective inmate's first point of contact with the institution's building, and thus *the* visible face of the almshouse. He acted at once as custodian and superintendant. While the Daily Occurrence Dockets may have been irrelevant and inappropriate in the eyes of the managers, for the historian the steward's narratives provide a wealth of information on a range of circumstances surrounding the lives of Philadelphia's indigent population.²¹⁶ Despite, and even because of their subjectivity, they provide a rich source pertaining to the lives of diseased women, given that Cummings went to considerable lengths to narrate his perceptions of his female venereal charges. As will be shown, they indicate his fierce resentment towards this group of almshouse inmates. In addition, when studied in conjunction with the records of the Manager's meetings, the sources provide a window into the power struggles between those in positions of authority and those who were subject to that authority. The interaction between the various officials and inmates did not constitute a simple bi-polar model wherein one group secured the submission of the other. Complicated power relationships were played out behind the walls of the almshouse, with Cummings a pivotal actor involved in this narrative. In the early republic, with no real precedent for indoor poor relief on this scale, those in positions of power were confused by new ideas of reform. As this chapter will show, continuous bickering, lax enforcement of rules and uncertainty over the true purpose of the almshouse provided the conditions to facilitate pauper agency. Such weak management would be central

²¹⁵ While less descriptive, the later Daily Occurrence Dockets are equally informative. They include for instance, name, age (not recorded previously), nationality, and occasionally information on how many years the pauper had resided in Philadelphia, in addition to occupation and marital status. There would also be an indication if the inmate was 'silly', an 'idiot' or 'intemperate'.

²¹⁶ The dockets shed valuable light on the customs of the poor and the circumstances surrounding their lives prior to admission to the almshouse. Together with the Managers Minutes, the sources also illuminate the development of the almshouse and its hospital and broader aspects of medical care. For detailed discussions on the social, economic and cultural aspects of Philadelphia's lower sorts as revealed within the Daily Occurrence Dockets see, Newman, *Embodied History*; Smith, *Lower Sort*. Newman and Smith have mined the dockets to creatively reconstruct the lives of Philadelphia's indigent and labouring population.

to the activities of diseased women, who were able to make use of the almshouse infirmary as and when they pleased.

2.1 The Managers

According to John Alexander, the American Revolution played an important role in leading more prosperous Philadelphia citizens to the conclusion that the poor were becoming more numerous, more visible and more worryingly assertive, ‘for it helped weaken systems of control that had worked to keep the colonial poor in check’.²¹⁷ The Revolution represented a break with the past when the community had been largely responsible for a relatively small number of poor people, and the almshouse (then known as the Bettering House) had existed as an instrument of reform for the deserving poor with those deemed the vicious and undeserving poor kept out. After Independence, Philadelphia’s population expanded dramatically and the numbers of impoverished grew just as fast. According to Smith, during the first quarter of the eighteenth century, the numbers of Philadelphians drawing on public poor relief rarely rose above 1 percent, yet by the closing decades of the century this had risen to 5 percent.²¹⁸ As noted, thousands of Irish immigrants disembarked at the city’s docks and entered the city, alongside migrant blacks (free and runaway slaves) and increasing numbers of vagrant white Americans in search of work. By the closing decades of the eighteenth century Philadelphia’s streets and wharves appeared overwhelmed by a sea of anonymous faces, turning the intimate Quaker town into a threatening city that all but overwhelmed city officials and leading citizens. Their response was to remove many of the problematic poor off the streets of the capital city, using incarceration in the workhouse and almshouse as an instrument of social control.²¹⁹

²¹⁷ John K. Alexander, *Render them Submissive: Responses to Poverty in Philadelphia, 1760-1800* (Amherst: University of Mass. Press, 1980), 25.

²¹⁸ As Newman and Smith note, this is a conservative estimate given that many Philadelphians did not qualify for public relief and instead relied on private charities. Simon Newman and Billy Smith, ‘Incarcerated Innocents: Inmates, Conditions & Survival Strategies in Philadelphia’s Almshouse’, Conference Paper Presented at ‘*Incarceration Nation: Voices from the Early American Jail*’, April, 2009, 4-5.

²¹⁹ During the late-eighteenth century vagrancy became a certified crime and the wandering poor could- through no fault of their own besides non-proof of residency- find themselves confined in the city workhouse (a branch of the Walnut Street Jail).

However, those in positions of authority appeared confused and vague in their ambition to regulate the lives of the poor. Michael Katz argues that ‘poorhouses had very clear goals: they were supposed to check the expense of pauperism...by deterring people from relying on relief’.²²⁰ This may be so, yet the Managers’ Minutes reveal that those in charge were often at odds over how best to organise the almshouse and treat its inmates. At the top layer of government the managers and overseers regularly agreed. While the managers were largely responsible for the good order of the house and its inmates, the Overseers of the Poor took charge of recommending paupers for admission. Throughout the late eighteenth century both sides frequently clashed over the collection of poor taxes and the nature of public relief. The Overseers of the Poor opposed eliminating outdoor relief, arguing that rather than the ‘cruelty’ of subjecting the poor to incarceration, small cash payments would ‘soon allow them to be self-supporting’. By contrast, the managers sought reform within the institutional setting; incarceration would keep the increasing numbers of poor dependent, and out of view of Philadelphia’s wealthier residents. Alexander has shown that the overseers and managers were drawn from divergent socioeconomic stations, often clashing to the extent that ‘the antagonism between the two groups ‘became quite bitter’.²²¹ The managers were drawn largely from Quaker and other urban elites, while a large number of Overseers were more middling mechanics or artisans and thus in touch with a more representative section of society. Rarely did the two groups who shared responsibility for the city’s poor agree on how to control and administer aid to those in need of help.

Over thirty years ago David Rothman contended that ‘just as the penitentiary would reform the criminal and the insane asylum would cure the mentally ill, so the almshouse would rehabilitate the poor’.²²² Historians have subsequently reached different conclusions over the aims of almshouse confinement, in particular whether desires to control the poor surpassed genuine philanthropy. Alexander argued that the almshouse was a place of control and punishment from its inception, a ‘house for remoulding the poor’. Charity, he explains, ‘was utilised as an instrument designed to

²²⁰ Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1986), 22

²²¹ Alexander, *Render Them Submissive*, 91, 92, 95-8.

²²² David Rothman, *Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston, Little Brown, 1971), 179.

reform the poor'.²²³ Conversely, Rothman claims that humanitarian sentiment prevailed over notions of social control and between the early national and Jacksonian years a kind of utopian vision informed reformers policies. In a similar vein to Rothman, Clement argued that while controlling the poor certainly had its place in reformers intentions charitable ends ultimately underpinned their aims, and those in charge,

generally exercised their authority in a benevolent fashion...[acting] in the best interests of the poor by providing them with a nourishing diet, attending to them personally, willingly granting them leaves...and extending to certain groups of the poor...special care...all [of which] reflect the charitable vision of Philadelphia's almshouse managers.²²⁴

Other historians have argued that the almshouse held out 'more punishment than reward'. The original plans and stipulations suggest the Guardians of the Poor sought to emulate and enforce prison-like conditions. As Smith notes,

...locked gates and a brick wall confined inmates to the ground and the steward's permission was required to enter or leave the house. Life inside was regimented as well. Inmates rose when a bell rang, retired at nine o'clock in the summer and an hour earlier in the winter, and ate together according to elaborate regulations.²²⁵

The able bodied were put to work to pay for their keep, as were the sick after they were moved to convalescent wards following a course of medical treatment. Rules were posted on the walls demanding diligent work and submissive behaviour; inmates were required to 'show respect to their superiors or governors' and to behave in an 'orderly, sober manner'.²²⁶ Inmates who repeatedly disrupted the order of the almshouse could be called in front of the magistrates and subsequently sent to the workhouse in the prison. Alcohol was prohibited (except when prescribed by doctors or given as a reward for good behaviour). In short, many aspects of this formally disciplined and ritualized almshouse life, along with a general lack of personal freedom did indeed mirror imprisonment in the Walnut Street Jail.

²²³ Alexander, *Render Them Submissive*, 8, 34 and 110-17; Newman, *Embodied History*, ch.5; Rothman, *Discovery of the Asylum*, xii-2. The word 'almshouse' itself is vague, as the term workhouse, almshouse and poorhouse were used interchangeably by contemporaries as well as later historians and social scientists. For a fuller discussion on the use of these terms, see David Wagner, *The Poorhouse: America's Forgotten Institution* (Lanham: Rowman & Littlefield, 2005), 3-5.

²²⁴ Priscilla Ferguson Clement, *Welfare and the Poor in the Nineteenth Century City: Philadelphia 1800-1854* (Rutherford: London, 1985), 37-8, 84-5.

²²⁵ Smith, *Life in Early Philadelphia*, 36.

²²⁶ Clement, *Welfare and the Poor*, 88.

However, the Minutes reveal several instances of the managers perceiving their institution as a benevolent household, with paupers and keepers living in a familial environment. As such, they envisioned their institution as a homelike-setting where inmates were part of ‘our extended family’.²²⁷ The corrective or punitive character of the house was sometimes downplayed in favour of more humanitarian intentions to reform its inmates. Thus, although management was ‘occasionally reduced to the necessity (however irksome) of Inflicting punishment’, they were quite clear that punitive measures should not ‘prove an injury to the offender’.²²⁸ Furthermore, external requests to admit vagrants or sick convicts from the Walnut Street Jail only served to irritate almshouse officials. As the managers frequently re-iterated at their meetings,

...they [vagrants] are sent to this House as to a place of confinement, punishment and labour...the intent of the [almshouse] Law is not, neither can it be answered from the Nature and Design of this Institution.²²⁹

Inmates were often rewarded for good behaviour, even known prostitutes. That said, and as is clear in their disciplinary procedures, there can be little doubt the managers ran a prison-like apparatus. Employing the language of incarceration, inmates were to be ‘detained’ or ‘confined under our care’ for ‘salutary correction’. However, theory was rarely adhered to in practice. For example, inmates regularly brought alcohol into the house both for personal consumption and to sell, and clothes were stolen to pawn in the outside world. Such behaviour did not go by unnoticed and in 1812 a visiting committee called ‘attention to the board of the very great want of proper cells in order to render them a place of real punishment’.²³⁰

In his study of the Walnut Street Jail in Philadelphia, *The Cradle of the Penitentiary*, Negley Teeters claimed,

²²⁷ 7 Dec. 1801, 3 Oct. 1787. M.M.

²²⁸ Ibid.

²²⁹ Ibid., Feb. 1789.

²³⁰ 15 June 1812. M.M. A visiting committee was appointed from the 1790s to investigate any reports of abuses. They regularly inspected the general order and hygiene within the house, and reported back to the managers who recorded their statements in the minutes of each meeting.

...the problems of prison management are legion. In a day when there were no precedents in prison management in America worthy of consideration, the inspectors and friends of the new system in Philadelphia were obliged to develop a new philosophy.²³¹

Teeters' summary of the managerial uncertainty over the nature of the city's jail closely mirrors the confusion that characterised the aims for and the internal order of the almshouse. Lack of strategy often resulted in a loss of control, and this can be seen most clearly in the ways that inmates were able to bend or simply disregard the rules. For example, Francis Martin was discharged by the steward after she was 'detected in breaking the Rules & Orders of the House by taking in Spinning & doing it here...at the same time neglecting the work she ought to do for this Institution towards her support'. As a consequence, she was 'Turned out as unworthy taking her young child with her'. Francis Martin is just one example of many inmates who used the facilities of the almshouse to benefit her in the outside world. Male and female inmates congregated together when it was forbidden, and prostitutes may well have found a ready market not only on the streets but also behind the walls of the almshouse. In 1789 the managers complained of 'the facility of Intercourse between the Men and Women thro the Ruinous state of the Fences'. Cummings was directed by the managers to 'have the Fence which divides the yard made as High & Secure as possible, in order that all Improper behaviour between the Sexes may be Prevented'.²³²

A particular source of irritation to the managers was the ease with which inmates were able to escape, particularly those suffering from venereal disease. This was done by scaling the fence and eloping, or by simply walking out with a pass issued by administrators and not returning. This practice was so common the managers complained in 1789 that, 'the people of the House have too much the Liberty of coming and going at their own Discretion'.²³³ A decade later the same problems were apparent. In 1799 the matron of the almshouse protested that 'persons admitted as paupers into this institution have without leave...been allowed to go into the city and

²³¹ Negley Teeters, *The Cradle of the Penitentiary: The Walnut Street Jail, 1773-1835* (Philadelphia, 1955), 57.

²³² 8 and 9 Mar. 1789, M.M.

²³³ Ibid., 24 Sep. 1788.

returned drunk'.²³⁴ Thus, although managers strove to 'detain' inmates, in practice many came and went as they pleased.

2.2 The Steward

John Cummings was the first point of human contact for all inmates. When a pauper was approved for admission by the Overseers it was the steward who met the new arrival after he or she passed the gate keeper at the front entrance of the building. Thereafter, it was the steward who recorded the inmate's particulars in the dockets, supervised bathing and issued a change of clothes. After consulting a medical attendant, he or she would be assigned to a ward in the infirmary or the house of employment. The steward was also responsible for overseeing the behaviour of inmates. John Cummings held his own particular ideas about how to govern his charges. This is highlighted in a letter he sent to the steward of the Pennsylvania Hospital in 1797, regarding the practice of sending almshouse inmates who habitually violated regulations to the Walnut Street Jail. The almshouse steward lamented that,

...the disorderly in the almshouse on the Complaint of the Managers are committed as Vagrants to the Gaol...is this not a shameful prostitution of Law and of the humane and benevolent designs of the first founders of the Institution.

Instead, Cummings proposed a separate workhouse be erected beside the jail, more along the lines of the house of employment. Here, disorderly inmates would be 'committed from one to six months...to be credited with their labours', in order to 'prevent the disgraceful punishments which never fail to harden and debase the mind'. He further suggested that there be 'solitary or penitentiary cells to which the disorderly be confined... [that] not be to punish but *reform*'.²³⁵ The steward was more explicit than the managers in his belief that the almshouse should serve a rehabilitative function, rather an institution of punishment, and his words are suggestive of someone who perceived the poor relief system as unfair. Perhaps he saw the potential amongst his unfortunate charges and believed that they could be remoulded into decent citizens. The managers, divorced from the daily realities of the

²³⁴ 14 Jan. 1799, M.M.

²³⁵ 'Letter from Steward of House of Employment to Steward of the Hospital', 7 February 1797, Box 189, PHA.

institution, proved less amiable. Cummings' opinions may have differed from the managers in part because he did not hail from the rank and file of the better sorts like those who acted as managers. It was likely the steward was recruited from the lower middling sorts in the first instance, given that his language and writing was of the calibre of a man that was somewhat educated. As steward of the almshouse, the managers counted upon his co-operation in carrying out an overwhelming range of domestic tasks alongside his wife, who acted as matron. Yet, Cummings answered to the managers despite having more personal contact with, and knowledge of the inmates, and he was in essence *the* primary source of institutional surveillance and contact with all inmates. For over thirty years, the steward came face to face with the most miserable human conditions, which must have elicited some amount of sympathy.

Despite his faith in the almshouse as a benevolent institution of reform, Cummings regarded diseased women in an altogether different light. A letter sent to the steward of the Pennsylvania Hospital is particularly representative of Cummings' feelings towards his female venereal charges. Sick almshouse paupers were often sent to the Pennsylvania Hospital at the charge of the almshouse, as were their clothes. The steward wrote,

Herewith you will receive...the necessary Clothing for the female patients now in the Hospital and when you find any real necessity for a further supply of Linen let me know of it; I will endeavour to furnish it as soon as possible-some Distinction in the Distribution should be attended to; such a worthless Hussey as Anne Daily- should only be supplied *barely* with those things.²³⁶

Inmates commonly ran off with the institution's clothes; so why was Anne Daily singled out amongst a group of men and women who habitually eloped from the almshouse? The early national years preceded an era during which prostitutes were increasingly perceived as *the* agents of venereal transmission, and during Cummings time attention was directed towards the moral regulation of prostitution. Historians of the early national period have shown that a culture of sentimentality emerged during

²³⁶ 'Letter from Steward of House of Employment to Steward of the Hospital about clothing for patients', 26 Jan. 1795, Box 189, PHA. An examination in the Pennsylvania Hospital Managers Minutes confirms several almshouse patients sent to the Hospital abused the rules in the more prestigious hospital. Ann Daily, at this time, was the only prostitute.

the closing years of the eighteenth century, with prostitutes often recast in passive terms of victimization. According to Lyons, the ‘joking gibes about forward women engaging in adultery were...replaced with sentimentalized tragic stories of fallen women’. Thus, ‘adultery, once the source of ribaldry, was no longer represented as funny’ as is evident in popular literature of the time.²³⁷ Cummings, who was clearly intimidated by working class sexuality, did not accept this cultural reconstruction of sexual deviance. The harsh realities of the almshouse were not the stuff of sentimental fiction and the steward refused to buy into the tales of seduction.²³⁸ A narrative that essentially stripped sexual transgressors of agency did not correlate with his experience and accounts of the conduct of his diseased charges. He repeatedly blamed diseased women for both their own condition and that of their patrons. Peggy White for instance was blamed entirely for her condition: ‘she is Discharged at her own Request for the Propagation [although] not of the Gospel’. Sarah Evans was simply reported as ‘gone to inoculate’. Male venereal inmates were far less prone to suffer his caustic words, and gender-specific remarks filled his records. On Mary Killgallant’s admission note, his remarks were especially scathing, ‘I am real[l]y glad that I never was a *gallant* of yours, tho (sic) probably a good fellow has been, and that you kill[e]d them all *dead, dead, dead*, over and over *again* and *again*’. For the most part Cummings made a distinction between those he perceived to be victims of syphilis -including unsuspecting men and innocent wives- and those who spread the infection. Thus, he exhibited a degree of sympathy for twenty year old Sarah Yates whose husband ‘deserted her, but took care before he went off to give her the Venereal Disease’.²³⁹

Diseased women were a constant source of amusement to Cummings throughout the 1790s. He was relentless in his mockery, particularly towards those he believed were prostitutes. Frequently depicting the prostitutes of the port city in nautical terms, Cummings developed his own system of identification and classification amongst all

²³⁷ Lyons, *Sex among the Rabble*, 313. For a similar analysis in Britain, see Randolph Trumbach, *Sex and the Gender Revolution* (Chicago: University of Chicago Press, 1998), 184.

²³⁸ For a full interpretation of how prostitutes -and indeed any woman who engaged in non-marital sex- were represented in fiction of the period see Lyons, *Sex among the Rabble*, Chapter 3. For an example of how reformers used the tales of seduction to inform policies in the Magdalen Asylum. See Rodney Hessinger, *Seduced Abandoned and Reborn: Visions of Youth in Middle-Class America, 1780-1850* (Philadelphia: University of Pennsylvania Press, 2005), ch. 2.

²³⁹ Sarah Yates, 15 June 1800; Peggy White, 10 Jan. 10 1791; Sarah Evans, Mar. 1796; Mary Killgallant, 10 Feb. 1796, Dockets.

his pauper charges, and diseased women did not come off lightly. When Ann Hill was discharged 'she was now prepared for another desperate cruise...a real Fine Ship and a sulphurous bomb...just turned out of dock...not with clean bottoms but very fit for mischief'. When Eleanor Murrin was discharged she was 'Boot Topped...Hoved down [and] polished over' so she could 'sail again'. Such women were more often than not labelled 'one of the Venereal crew', while Elizabeth Boyd was the 'skipper of the ward'. And like most ships that docked in and out of Philadelphia's harbour, Cummings' language was suggestive of their imminent return, as with the case of Mary Cope 'a constant trader' who made 'more trips in & out of this port'.²⁴⁰ Diseased women were caricatured by the steward, drained of individuality and essentially dehumanized. As Robert Jutte has noted, 'a favourite linguistic technique used to stigmatise persons is the use of derogative nicknames'.²⁴¹ Nicknames were often used by the steward to emphasise otherness, and also to set him and other inmates apart from the venereal women. Cummings felt the need to employ this tactic in order to reassert his place as a superior by belittling those under his charge, and to separate those he hoped might be helped by the Almshouse from those who would not accept personal reform.

The Daily Occurrence Dockets also indicate how the steward perceived seemingly audacious lower class women, and his vocabulary suggests a significant number of diseased women came across as loud and assertive (and perhaps frightened). They alarmed Cummings, and humour with a haughty response was his defence. Prostitution was perceived by contemporaries as the most patent symbol of female economic and sexual independence.²⁴² Thus, prostitutes offended the men who ruled Philadelphia and its almshouse, and consequently they viewed independent women with suspicion. When Mary Vandlike was admitted with a more socially acceptable illness, Cummings was perturbed that she was 'neither maid widow nor wife But a single woman...as to her character it may hereafter appear'.²⁴³ Many lower class women were not disconcerted by their independent status, and if they were, few showed any sign of it. Carol Lasser argues that lower sort women held a different

²⁴⁰ Ann Hill, 4 Jan 1792; Eleanor Murrin, July 1797; Elizabeth Boyd, 9 Aug. 1794; Mary Cope, July 1794, Dockets.

²⁴¹ Jutte, *Poverty and Deviance*, 162.

²⁴² Lyons, *Sex Among the Rabble*, 320.

²⁴³ Mary Vandlike, 27 Dec. 1793, Dockets.

comprehension of womanhood to those from the more prosperous classes.²⁴⁴ As we shall see in the next chapter, the records present a group of women intent on provoking a reaction by accentuating their own autonomy and agency. Overall, Cummings appears to have been intimidated by such explicit working class independence and sexuality displayed by many of the women he encountered.

Although his depictions of infected woman appear amusing, the steward's humour was harsh and potentially harmful. The notations concerning female venereal inmates were laced with quite sinister connotations while his entries concerning male venereal charges were not as emotionally charged. Occasionally Cummings would castigate large numbers of venereal inmates -both male and female- who passed in and out the institution, and he could not always hide his irritation that they came and went with relative ease. When Jeremiah Cronin was admitted in December 1790, the steward bemoaned that 'some examples are not made...of those numerous Dirty Fellows & Hussys who so repeatedly Burthen...this Institution with this filthy disease and still with Impunity'.²⁴⁵ Financial resources were never far from the mind of the steward, thus Mary Cope was 'an unprofitable customer'.²⁴⁶ However, on this occasion his remarks on the 'Dirty Fellows & Husseys' were directed towards the financial drain venereal inmates posed to the institution, and not their gender or diseased condition per se. For the most part, men suffering from venereal infection were simply noted with mild stock-phrases such as 'idle venereal fellow' or 'worthless skulker'. At worst male venereal patients were ridiculed with comical names, such as John Roberts, otherwise known as 'Cock Robin'. Roberts, along with Mary Carroll one of his 'adopted wives', kept 'a most infamous place of Rendezvous' and frequently came under the watch of the city constables for a variety of illicit activities. John Roberts appears to have acted as a pimp, although in a very disorganised and loose sense of the term.²⁴⁷ Along with her 'equals', Mary Carroll would 'debauch in every way' and

²⁴⁴ Carol Lasser, 'Gender, Ideology and Class in the Early Republic', *Journal of the Early Republic*, Vol. 10, No. 3 (1990), 335.

²⁴⁵ Jeremiah Cronin, Dec. 1790, Dockets.

²⁴⁶ It is likely Cummings came under management pressure to economise. He often let his vexation surface in relation to the economic drain on the institution by prostitutes. The managers frequently made comment at their meetings that they required both the physicians and steward to discharge those inmates deemed fit enough to be released.

²⁴⁷ During this period prostitution was controlled for the post part by women, whether inside the brothel or on the streets. As Stansell notes, 'pimps were a phenomenon of the early twentieth century, a consequence of the onset of serious police harassment'. Stansell, *City of Women*, 174.

often steal 'Cloaths & other Property of the Public'. On one occasion Mary and Eliza McSwain 'also a Noted Madam lately sailed on a Short Cruize' taking the clothing of fellow inmates', including a 'Gown, Petticoat, Shift, Shoes & Hose with her Apron all for 6 shillings which was all Spent to Release J Roberts (Cock Robin) from Jail'. During one admission to the almshouse, Cummings devoted two full pages analysing Carroll's activities as thief and prostitute. John Roberts was never allocated the same amount of space as Mary in the steward's dockets, despite his notoriety amongst Philadelphians as a leading criminal and 'fellow among the Gang'. However, during one almshouse admission the steward entered him as,

...a 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 cooked him up indeed or fully or fowly done him over, he being highly venereal.²⁴⁸

While hardly portrayed as an innocent, it is significant that Cummings portrayed the criminal Cock Robin as a victim of preying diseased women. For John Cummings, prostitutes were agents of transmission of venereal disease.

Cummings presented his stories of Cock Robin and his followers in a somewhat comical manner, which lacked the more caustic tone of his accounts of female venereal cases. Cummings seldom accepted any kind of cultural or economic criteria as a legitimate or understandable reason for a woman's move into prostitution. This contrasts starkly with the mid-Victorian period during which time the Guardians of the Poor held interviews with diseased women, and encouraged them to present themselves as victims of male seduction or as desperate and suffering from biting poverty.²⁴⁹

That Cummings' found diseased almshouse women so objectionable, also raises the question of whether he was himself in fact diseased. He certainly displayed signs of madness in his frenzied chronicles, and syphilis in its tertiary stage often attacks the brain and nervous system. General Paralysis of the Insane was common amongst

²⁴⁸ Eliza McSwain, 16 Apr. 1790; Mary Carroll, Apr. 1790. Dockets.

²⁴⁹ Prostitutes Register, c. 1860-1863, PCA. The Register was kept by the almshouse over the course of the early 1860s. It is not known if others existed that may have been destroyed. It is interesting to note that while the Guardians of the Poor provided categories for women to comment on why they commenced work as a prostitute, a significant number preferred to cite the lure of the city as the key motivator rather than economic reasons.

syphilitics, and those afflicted with it accounted for a significant number of patients in nineteenth century lunatic asylums.²⁵⁰ If Cummings had contracted some form of disease through sexual relations with an infected woman, he was in the right place to access treatment. However, in October 1803 the *Philadelphia Repository and Weekly Register* recorded the death ‘on the 15th of an Apoplectic fit, Mr. John Cummings, late superintendent of the Bettering House’.²⁵¹ While there appears to be no evidence of previous illness recorded in the almshouse sources, if Cummings had suffered from some form of venereal infection it would have been unlikely to be revealed in public records. Syphilis rarely appeared on death certificates. Cummings’ apoplexy may well have been what we today understand as a stroke, and ‘the resulting paralysis [that] is frequently caused by syphilitic destruction of the wall of the blood vessel to the brain’.²⁵² Cummings’ wife had died in 1793 during the yellow fever epidemic, and perhaps the steward began sexual liaisons with some of the almshouses inmates after this time. His most scathing remarks against diseased women occurred in the years following her death. Another consideration is that his attitude towards diseased females was fuelled by resentment at the abuse his late wife had been subjected to by inmates and the managers. In 1784 reports appeared in the local newspapers that ‘shocking abuses prevailed at the almshouse’ and the Overseers appointed a committee to investigate. According to one source,

...all kinds of unwholesome food including maggoty butter had been served to inmates...[and] there was a lack of proper clothing. The person found responsible for this shocking state of affairs appears to have been Mrs. Cummings the wife of the Steward who acted as Matron of the House.

Consequently there was an overhaul of the institution’s affairs, and although not dismissed Mrs. Cummings ‘was much frightened by the exposure’.²⁵³ We will never know the reasons why Cummings waxed so vehemently against his female venereal charges. There is no evidence that he ever turned a venereal patient away, and he essentially allowed his authority to be undermined by the assertiveness of a group of

²⁵⁰ Jay Cassel, *The Secret Plague* (Toronto: University of Toronto Press, 1987), 18, 26-29.

²⁵¹ *Philadelphia Repository and Weekly Register*, Oct. 1803.

²⁵² Herbert M. Sheldon, *Syphilis, is it a Mischievous Myth or a Malignant Monster* (California, 1962), ch. 3.

²⁵³ Charles Lawrence, *History of the Philadelphia Almshouse and Hospitals* (Philadelphia: Printed Privately, 1905), 32.

women who clearly intimidated him.²⁵⁴ The steward evidently found a coping mechanism through private ridicule of venereal inmates. The dockets were intended as his private sentiments, being more of a personal diary than an official public record. In effect they were a source of comfort and escapism.²⁵⁵ His colourful metaphorical language and use of nicknames added a dramatic dimension to the sad lives of those he admitted.

To have direct contact with human misery on a daily basis for over thirty years would surely have been emotionally taxing for the most hardened person. At times Cummings found it difficult to reconcile his feelings towards diseased women with his impulse toward compassion for those whose indigence resulted in circumstances beyond their control. When known prostitute Ann Holland sought relief, despite having previously absconded and returning without a Recommendation, the steward bent management rules on account of 'her being destitute and having no shelter or place to go', thus he 'permitted her to stay'.²⁵⁶ The notations made by Cummings about Hannah Levy also illustrate his occasional compassion. We first learn of Hannah in 1793 when she was admitted as a 'non- resident...venereal strumpet'. No stranger to trouble, Hannah also appeared regularly in the Vagrancy Dockets as a 'lewd...disorderly...prostitute'. On several occasions in 1794 she was transferred from the workhouse to the almshouse. Thus, she was noted as 'brought here from the Jail very far advanced in the Venereal Disease' and on another came 'from the Jail severely bad with the Venereal'. Hannah was received by the almshouse on no less than ten occasions during the 1790s, frequently eloping after a few months of treatment. She was also the victim of bad luck. In 1801, she was 'brought in a cart' with a 'bruised and lacerated' face after being 'trod on by a horse'. That Cummings was exasperated by Hannah and found her repugnant is evident. In 1795 he labelled

²⁵⁴ On the occasions where a question mark hung over the head of a pauper seeking admission it was generally related to legal residence. If that person did not come under the jurisdictions of Philadelphia City, Northern Liberties or Southwark, he or she would be sent to the Guardians of the Poor who would deal with the relevant authorities responsible. This became more difficult to enforce however as the city expanded and faces became more anonymous.

²⁵⁵ This is especially evident when Cummings was asked to present the accounts which he clearly did not do to the satisfaction of the committee. That the steward kept these records as a personal pursuit is clear in an entry he made regarding the admission of Ann Wall in 1796. Wall was entered as 'the Noted and Infamous old Wo[ma]n who lately eloped, See the entry of her Character only last Wednesday & which is now Verified'. The managers were simply more concerned with financial matters such as proof of a pauper's legal residence and not a character reference. Ann Wall, 8 Jan. 1796, Dockets.

²⁵⁶ Ann Holland, 16 Mar. 1802, Dockets.

her 'an Impudent Hussey & former Customer', then in 1796 'a noted infamous Rotten venereal Hussey whom there is no such thing as keeping in or out but continually to & fro'. He also presented Hannah as an agent of venereal transmission, and when she jumped the fence the following month he caustically remarked, 'as Customary [she has] Ran off or gone forth To Propagate not the Gospel (for she is a Jewis) but the disease. On one occasion Cummings recorded Hannah as,

...violently deranged, but apparently very much Recovered, or restored to her reason. Her father on the 16 Instant and has permission to take her out upon Trial & in hopes of permanent Recovery, and as He hath not Returned her, nor called to give any account of her situation, it is hoped she is quite well.²⁵⁷

Her plight clearly elicited some uncharacteristic concern, and over the course of Hannah's almshouse experience it is probable Cummings pondered her situation with empathy. Cummings and his wife lived on the almshouse site, sharing all aspects of institutional life with inmates. On the outskirts of the city proper the almshouse was essentially his home, and having no children with his wife it is possible the steward often displayed paternalistic sympathy towards some of those inmates who frequently sheltered there. The steward occasionally displayed pity, and he took an interest in the welfare of some sick inmates, occasionally prostitutes.²⁵⁸ In fact, one can sense a degree of emotional attachment in several cases. For instance, when Elizabeth Saunders died from the effects of disease the steward noted her as 'one of our unhappy venereal Ladies of long standing here Expired this evening'.²⁵⁹

On several occasions Cummings also carried out economic transactions with known prostitutes, mostly through the purchase of flax and junk. Rachel Ward was noted as supplying the steward with 'junk material' in return for cash. In fact, despite the caustic language directed at Rachel in light of her repeated elopements throughout the 1790s, the steward nominated her in front of the managers to 'receive compensation for her services according to her merit or behaviour' in the 'polishing or venereal ward'.²⁶⁰ The steward may have felt sympathy towards the plight of the poor, or at

²⁵⁷ Hannah Levy, May, June, July 1793, Feb., June, Sep. 1794, July 1795, May, June, 1797, Mar, July 1800, Dockets; 12 and 24 June 1794, Vagrancy.

²⁵⁸ Hannah was admitted several times after Cummings departure from the almshouse before dying in November 1802, noted as an 'old venereal customer, the effect of which has caused her Death'.

²⁵⁹ Elizabeth Saunders, 4 May, 1794, Dockets.

²⁶⁰ 13 Aug. 1797. M.M.

least a certain affinity with them and some of the institution's inmates. Although his writing ability suggests he was of lower middling ranking, he may originally have come from a similar working class world of Philadelphia.²⁶¹ He was still nevertheless a manual worker, despite the clerical duties he carried out. Previous to his job as steward it is possible he was as vulnerable to the same seasonal economic downturns like many of the almshouse's paupers. During the early national period, poverty could touch anyone. By engaging in economic contracts (formal or informal) with those deemed by the better sorts as the lowest of the low, he clearly acknowledged the financial hardships of the almshouse's inmates, even prostitutes. By doing so, he was allowing negotiation and compromise between "those above" with "those below".

Cummings often expressed disdain at interference "from above" in his daily management of the house and his supervision of matters relating to inmates.²⁶² He was clearly protective of a role, which in theory was subject to the managers, yet in practice his work was essential to the maintenance of the house. It is likely that he resented the power of a group of men who came and went every six months, many of whom had little real knowledge of the daily operation of the almshouse, yet who were able to wield power over it. The managers were members of the Philadelphia elite and Cummings was jealous of their power and standing. He was overworked and frequently complained throughout the length of his appointment that his wages did not compensate the burdens of his services adequately. From as early as 1770, he protested that his salary was 'insufficient for the Services and Trouble attending his office'.²⁶³ I can only find one instance when Cummings was in fact consulted over the running of the internal management of the institution.²⁶⁴ The trouble caused by his methods of record keeping was not the first time he had found himself under the wrath of the managers. According to Lawrence the managers,

...did not hesitate to censure or punish when they felt it was deserved. The minutes of December 15th, 1788 record that "The Steward and Matron of the House of

²⁶¹ While there is no information relating to his previous life before residing in the almshouse, it is possible he was familiar with the brothels and taverns of Philadelphia's working class neighbourhoods.

²⁶² R.J. Hunter, *Origin of the Philadelphia General Hospital, Blockley Division* (Philadelphia: Rittenhouse Press, 1955), 29.

²⁶³ 21 May 1770. M.M. The steward also threatened to resign on several occasions if his salary was not increased by the managers.

²⁶⁴ 6 Dec. 1796. M.M. Cummings was consulted over the appointment of a visiting physician's assistant.

Employment were reprimanded on account of some unexplained deficiencies in the returns of the spinning department. The Board adopted the following rule: "That in future all deficiencies not regularly and satisfactorily accounted for, shall be charged to the Steward or Matron, where such circumstance occurs under his or her department, and the value of the same shall be stopped out of his or her wages!!"²⁶⁵

Moreover, the steward had far more personal involvement with inmates than did the managers, especially those who came and went on a regular basis. Most inmates would never meet the managers, and their only experience with the Overseers would have been during the initial interview to gain an order for admission. Cummings' actions and beliefs did not always fit in with the wider strategy of those in positions of power to contain poverty, criminality and idleness. He played a huge role in almshouse administration, and the effects of his behaviour had a profound effect on the institution's management and internal organisation. That Cummings was essentially unsupervised in his position would have profoundly affected how a pauper experienced his or her stay.

Thus, Cummings struggled to exert some form of control over his charges, yet was also willing to accommodate and bargain with inmates. As a middle-man between civic authorities and residents, he may have felt more contempt for those above him than those below being more willing to compromise with paupers he believed deserving of sympathy. The managers were constantly engaged in a struggle to control inmates, and the steward jealously strove to retain as much influence as possible.

2.3 The Physicians

Power struggles did not exist solely between these two groups and the medical department proved to be a continual thorn in the side of the almshouse managers. As Cummings was constantly striving to exert his standing in the pecking order he often vented frustration towards the physicians of the house, a group of men who simply did not share his visions of how the almshouse should function. Such antagonism over the balance of power between the lay and medical men of the almshouse was a

²⁶⁵ Charles Lawrence, *History of Philadelphia Almshouse* (Philadelphia: Printed Privately, 1905), 37.

recurrent theme throughout the period, and both the Managers' and Physicians' Minutes bear witness to ongoing battles between the two sides. The managers struggled to retain control over almshouse therapeutics, and frequently the medical board were on the receiving end of management's prime concern to economise. According to Charles Rosenberg, while lay and medical men were from a similar social class, they held quite different opinions to the division of responsibility, as well as the actual purpose served by the infirmary wing of the almshouse.²⁶⁶ Despite the early aims of officials, by the early nineteenth century the almshouse was taking on a major role as one of the country's leading centres for clinical teaching. This was in part due to Philadelphia's standing as the 'seat of medical science before all other places in the United States'.²⁶⁷ Given its medical and intellectual standing, it is of no surprise that physicians held the hospital to be the most important wing of the almshouse, while the lay trustees regarded the infirmary as just one concern amongst many.²⁶⁸ In the late nineteenth century, ex-almshouse physician David Agnew looked back upon his days as resident physician, recalling the 'pompous tyranny' of the managers and noted, 'several of them were conspicuous for exhibiting their power...not only over paupers and patients, but over the medical residents also'.²⁶⁹

The managers did not originally intend the almshouse to serve as the city's key medical provider, and they certainly did not initially have any strategic plan as to how medical wards should be run. While they acknowledged that as a consequence of illness the sick would fall into poverty, the managers assumed this would be temporary, and the almshouse would ameliorate such occurrences. The very idea of being medically treated within an institutional setting was alien to most Americans, who, whether rich or poor were treated at home. Poorhouses were associated with pauperism not sickness, and most Americans believed the sick should be nursed at home. During the eighteenth century, there is little evidence to suggest the managers envisioned the poorhouse as more than a welfare institution let alone a primary medical care provider. However, by the end of the century the institution was increasingly assuming the role of infirmary, as is made clear by admission lists for the

²⁶⁶ Charles E. Rosenberg, *The Care of Strangers: the Rise of America's Hospital System* (Baltimore: John Hopkins University Press, 1987), 49.

²⁶⁷ *Ibid.*, 60.

²⁶⁸ *Ibid.*, pp.52-4.

²⁶⁹ Agnew, 'Reminiscences', 57.

period. According to Rosenberg, by the first decade of the nineteenth century the Pennsylvania Hospital housed between thirty and sixty at any one time but the almshouse contained an average of two hundred sick residents.²⁷⁰ For the year 1800 to 1801, Smith has calculated that around 60 percent of the almshouse population were admitted as medical related cases.²⁷¹

Control of medical practice was the source of much disagreement between the two sides, particularly regarding medical students. Although by 1800 the almshouse was increasingly beginning to resemble a charity hospital, the lay board clung to their control of the appointment of medical staff, including the house physician.²⁷² Resident physicians regularly requested that the managers permit medical students access to the infirmary wards. This request fell on deaf ears time and time again before the managers backed down and students were allowed admission, albeit under strict regulations. The managers and doctors regularly clashed over medical education within the almshouse, and the lay board remained adamant that ‘no patient should be presented to a class against his or her consent’ much to the annoyance of medical men desperate to provide their students with illustrative clinical cases. Physicians and surgeons disagreed with the managers over autopsy policies as they sought to provide greater opportunities for post-mortems and dissections. Furthermore, it took a decade for the managers to agree to the medical board’s repeated requests that each ward benefit have a ‘regularly trained nurse of good reputation’ rather than relying on pauper inmates to undertake this role.²⁷³ Discipline among and control over junior medical staff also proved a source of friction.

Such differences in opinion between the managers and medical appointees often took the shape of power struggles over who ultimately controlled patient care. Senior physicians such as Samuel Duffield and Casper Wister regularly complained about poor standards of almshouse care that seemingly met with the approval of the managers.²⁷⁴ For instance, they suggested not enough ‘attention is paid to the washing

²⁷⁰ Charles E. Rosenberg, *Explaining Epidemics and other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 181.

²⁷¹ Smith, *Lower Sort*, 169. These cases are categorised as sick, venereal disease, alcoholic and pregnant.

²⁷² Rosenberg, *Explaining Epidemics*, 195, 198.

²⁷³ *Ibid.*, 195.

²⁷⁴ For example see Dec. 1788, 16 and 25 Mar. 1789, 5 July 1791, M.M.

and cleaning of paupers as they come into the house'.²⁷⁵ On the other hand, the managers frequently bemoaned that the physicians kept patients under their care longer than was necessary. Both the Managers' and Physicians' Minutes reveal numerous occasions when the medical team attempted to bargain for better care for those inmates suffering the painful effects of venereal disease. This proved to be a continuous source of disagreement throughout the eighteenth and well into the nineteenth centuries. Venereal disease was perceived by laymen as being as much a moral as well as medical condition, with victims to be treated accordingly with a punitive dose of medicine. Yet, as the nineteenth century progressed physicians took a greater stance on perceiving venereal disease as a health issue above all else.²⁷⁶ As such physicians increasingly disagreed with the treatment of venereal patients as described by Rosenberg,

They [venereal patients] were made to work whenever possible, and the resident physicians were given special powers to discipline these bawdy and unremorseful objects of municipal benevolence. Their diet was 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.²⁷⁷

The physicians showed a good deal more compassion towards venereal patients than historians have realised. Resident doctors frequently clashed with the managers over the inferior food served to sick inmates, especially venereal patients. During one meeting in 1789, 'Drs. Duffield, Griffith & Leib waited on the Board to confer on matters relative to the Diet of Venereal & other Patients'. They further complained of 'difficulties attending their Practice in general...obviated by [the managers] Regulations'. While the management board 'united with them on the propriety and usefulness of their Propositions', the almshouse managers nevertheless, 'waived entering on the business at Present'. Apparently the managers were more concerned at this time to deal with the 'great consumption of Wine & Brandy' by the medical

²⁷⁵ 2 Feb. 1801, M.M. For other instances of squabbles between managers and physicians over the medical care of patients see Guardians of the Poor Physicians' Minutes, PCA.

²⁷⁶ This became increasingly so as the health problems inherent with industrial development became more apparent in the later nineteenth century. Physicians and reformers devoted to improvement created public health bodies to deal with the spread of diseases including venereal infections. On the development of public health and preventive medicine in America see, Elizabeth Fee and Dorothy Porter, 'Public Health, Preventive Medicine and Professionalization: England and America in the Nineteenth Century', in Andrew Wear (ed.) *Medicine in Society: Historical Essays* (Cambridge University Press: Cambridge 1992), 249-75.

²⁷⁷ Rosenberg, *Explaining Epidemics*, 187.

department who freely prescribed alcohol to their patients. Thus, they demanded 'more close Attention' should be paid to the 'Medical Concur of the House'.

Squabbles over therapeutics remained a constant source of conflict from the 1780s on. In a letter to the physicians in 1816, the managers expressed their view that the practice of giving 'Laudanum, Liquor & Spirituous preparations to persons under Medical Treatment...be abolished'. This matter reached boiling point in 1821 when the managers demanded a medical list providing an 'accurate account of the quantity of liquors consumed in the medical wards under their care'. The physicians were unable to produce a report, much to the disgust of the managers.²⁷⁸ Economic concern was often clothed in the language of evangelicalism and temperance. As the managers claimed in a letter to the physicians in 1821, 'the Commission has learned that many diseased and debilitated persons are admitted into the Almshouse, whose disposition originates in intemperance'. The almshouse authorities suggested that the physicians were to blame for exacerbating 'the causes and extent of pauperism' by the 'Quantity of Malt Liquor, Wine & Ardent Spirit' used for therapeutic purposes.²⁷⁹ The surgeons were also criticised for needless expenditure after purchasing equipment that cost more than the amount allocated for the purpose. They backed down, declaring,

...with the view of preventing future disagreements in the Medical Services, it is proposed that when...Surgical Apparatus is unusually costly in Character, the attending surgeon or Physician shall furnish his order... [to] be submitted directly to the chairman of the hospital committee.²⁸⁰

As well as clashing with the almshouse managers, the physicians also frequently irritated John Cummings. The case of Ann Floatnogle is illustrative. One of Cummings's 'infamous husseys', Ann was admitted in December 1791 suffering from venereal infection. While there appears to have been no love lost between patient and steward, the doctor in charge of Ann was less interested in moral justice and more concerned with her well-being. Cummings noted that 'it is said this woman is Disordered'. Yet the steward appeared to have reservations, being exasperated that

²⁷⁸ 3 Sep. 1789, MM; 18 March 1816, March 1821 Physicians Minutes, Hereafter cited as P.M. Despite Duffield's medical expertise and reputation -not to mention a long standing in almshouse service- the managers dispensed with his services on account of a mistake he made by admitting an infectious patient. 30 Aug. 1801. M.M.

²⁷⁹ Letter Sent by Managers to the Physicians, 12 June, 1821, P.M.

²⁸⁰ Rules and Regulations, 1834, P.M.

‘by the advice of the physician’ she is ‘sent for the recovery of her Health’. One can imagine Cumming’s frustrations when a month later Ann and two other ‘infamous venereal husseys scaled the Fence’.²⁸¹ There are also many instances when the steward appears perturbed by the physicians’ choice of sick paupers to be treated in the infirmary. For example, in a case of yellow fever, Cummings was alarmed that a doctor would let someone suffering a potentially deadly disease into the almshouse. When a ‘black man very Ill with a West India Disorder, a dysentery and a fever’ was admitted, Cummings noted this as an ‘alarming *Case*...for he was lately...smuggled into this port’. He further lamented that ‘surely such a Case should have been fully examined...before a man so probably *dangerously infected* should have been sent here’.²⁸²

Relations between the physicians and the steward could be as antagonistic as those between other groups in positions of authority. Squabbles over financial matters as opposed to medical priorities and teaching privileges often appeared as trivialities, and although these tensions did not boil over to crisis point, they nevertheless simmered throughout the nineteenth century.

Six months after the disgrace brought upon Cummings for his indecent methods of record-keeping, the steward retired from his job after decades of service. However, the details and nature of his retirement appear rather hazy.²⁸³ According to the managers,

In consequence of John Cummings having sent in his Resignation as steward of the almshouse and requesting time to move his effects...that he be allowed until the 20 March to remove all his furniture & to make way for his Successor.²⁸⁴

Very little has been written about Cummings. And what little has been, presents the almshouse steward mostly in a positive light. In his institutional *History of the Philadelphia Almshouse and Hospitals*, Lawrence contends that

²⁸¹ Ann Floatnogle, 27 Dec. 1790, 7 Feb. 1791, Dockets.

²⁸² 21 May, 1796, 25 May, 1796, Dockets.

²⁸³ After his retirement, there seems to have been a scandal regarding his pension. This involved lawyers, and resulted in Cummings being forced to hand back his pension. For a short reference to his retirement see Hunter, *Origin*, 33.

²⁸⁴ 16 Feb. 1801, M.M.

The brave and faithful Cummings continued in the service of the institution for more than thirty years, at the end of which age and infirmities compelled him to resign. No officer could have had a greater claim on the gratitude of the public. Honest, industrious, intelligent and resolute, he was always at his post ready to make a sacrifice for the benefit of those under his care.²⁸⁵

‘Brave and faithful’ he may well have been. After the yellow fever epidemic in 1798, Cummings and his family (nieces) were thanked by the committee of managers for the extraordinarily ‘dangerous and difficult situation’ placed on him, and in particular, the ‘firm, intrepid & vigilant attention to the...duties of his office’.²⁸⁶ Unlike the managers who could afford to escape the city during times of epidemic disease, it was unlikely that Cummings had such a choice. Although the managers often thanked the steward for the variety of duties he carried out, this appears to have been an annual ritual of lip service carried out when the board changed hands, rather than sincere gratitude.²⁸⁷

The steward was also requested to ‘move his plants’ when he retired, which suggests a different version of events. During his appointment as almshouse steward, it appears Cummings had apparently been trying his hand at a horticulture business in order to supplement his income. Several advertisements appeared in the *Philadelphia Gazette and Universal Daily Advertiser* in 1794 publicizing, ‘a fresh and general assortment of flower seeds...flowering shrubs and plants’. While the public could purchase these ‘on Market days’ at the stall of ‘Mr. David Landreth’ they could also place orders with ‘Mr. John Cummings at the House of Employment’.²⁸⁸ In October 1801 having left the almshouse, Cummings placed a notice in *Poulson’s American Daily Advertiser* announcing his new business at premises on the ‘corner of Walnut and Eleven Streets’. Here, the buyer would be ‘gratefully attended to’ and supplied with ‘a large collection and great variety of very fine double Hyacinths...tulips, crocuses &c, &c for sale at very reduced prices by the dozen, hundred or bushel’.²⁸⁹ There is a possibility then that the steward was forced to resign, especially in the wake of the scandal surrounding his record-keeping. If old age and ill-health were behind his departure, it is unlikely that he would have commenced a new entrepreneurial

²⁸⁵ Lawrence, *History of Philadelphia Almshouse*, 42.

²⁸⁶ 27 Mar. 1799, M.M.

²⁸⁷ For example see 25 Mar. 1797, M.M.

²⁸⁸ *Philadelphia Gazette and Universal Daily Advertiser*, 14 Mar. 1794

²⁸⁹ *Poulson’s American Daily Advertiser*, 20 Oct. 1801.

adventure. In fact, the managers may not have known about his sideline activities until his 'resignation'. We will never know the exact details of his retirement, or if his death a couple of years later was the result of venereal infection.

The narratives from the Daily Occurrence Dockets, Managers' Minutes and Physicians' Minutes illuminate the various power struggles within the Philadelphia Almshouse. Managers and overseers quibbled over the aims and nature of the almshouse; managers and physicians engaged in a constant struggle over the care of inmates, and the steward John Cummings, essentially a middle-man with conflicting agendas, was at the centre of these conflicts. Cummings did hold power, yet he was aware of its limitations. In the face of internal strife and little semblance of organisation from those in positions of authority, we have been left with vague or contradictory explanations as to what purpose the almshouse really served. Confusion in intention and discrepancies between theory and practice were exacerbated by tensions between those in positions of power. That the managers used the term 'almshouse', 'bettering house' and 'house of employment' interchangeably suggests there was no clear definition of motives over the nature of the house. Thus, as Alexander notes, the managers eventually came to the realisation that 'the original plan of the house was ill conceived'.²⁹⁰ This confusion and division was part and parcel of the social upheaval inherent within Philadelphia's expanding market-economy. The consequences were increasing social problems associated with urbanisation, as the emerging middle classes attempted to carve out a definable social space somewhere between the ranks of the lower classes and the better sorts. John Cummings was also attempting to define his own space in the face of exclusion from the decisions made by the almshouse governors. Behind the walls of the almshouse, and in the face of often weak management, the able-bodied and sick poor were able to negotiate their own space. As we shall see, this was most particularly the case with female venereal inmates who were able to use the institution in ways not predicted by its founders.

²⁹⁰ Alexander, *Render them Submissive*, 99.

Chapter Three

‘those insolent hardened Husseys go on dispensing all Rule & Order here’: the view from below

The American Revolution had profound and wide-ranging consequences for Philadelphians. Historians accept that the Revolution ‘assumed its most radical form in Pennsylvania’, particularly as a consequence of Philadelphia’s lower sort becoming ‘actors in the political drama’ of militia policy. An alliance with members of the middling classes overthrew the proprietary government dominated by the city’s Quaker elite, ensuring the most democratic government of any state.²⁹¹ In the wider Atlantic world, the French and Haitian revolutions stimulated further concern amongst America’s better sorts about the role of various groups, including not only the lower sorts but also African Americans and women. The Age of Revolution thus inspired a degree of social levelling: patriarchy was contested in a variety of ways, and marginal groups began questioning the deferential nature of colonial society. The Fort Wilson incident of 1779 illustrates such social levelling, with the Philadelphia militia demonstrating in the streets against high bread prices. Moving to ‘the beat of the rogue’s march’ they arrested a group of merchants believed to be opposing price regulation.²⁹² By doing so, this group of Philadelphia’s lower sorts were in effect challenging their own radical leaders. Thus, as Alexander notes, cracks became visible in the social hierarchy as the poor began to ‘shed some of the trappings of deference’.²⁹³ Coupled with a breakdown in colonial familial institutions and a subtle revolution in Philadelphia’s sexual behaviour, these developments together sparked a conservative backlash against the many democratic ideals of the Revolution.²⁹⁴ As outlined above, what was perceived to be social corruption amongst the poor led to

²⁹¹ Steven Rosswurm, ‘Equality and Justice, Philadelphia’s Popular Revolution, 1775-1780’, in Billy G. Smith, *Life in Early Philadelphia: Documents from the Revolutionary and Early National Periods* (Philadelphia: Pennsylvania State University Press, 1995), 247-8. Also see John K. Alexander, *Render them Submissive: Responses to Poverty in Philadelphia, 1760-1800* (Amherst: University of Mass. Press, 1980), 4.

²⁹² John K. Alexander, ‘Fort Wilson Incident of 1779: A Case Study of the Revolutionary Crowd’, *William and Mary Quarterly*, 3rd ser. 31 (1974), 589-612. Much of the research on eighteenth century plebeian working class consciousness has been inspired by Edward Thompson’s English study, which revealed a widespread plebeian culture of collective action working to fix food prices. For a discussion see Tim Hitchcock, *Chronicling Poverty: The Voices and Strategies of the English Poor, 1640-1800* (Basingstoke: Macmillan Press, 1997), 2.

²⁹³ Alexander, *Render Them Submissive*, 25.

²⁹⁴ Clare E. Lyons, *Sex Among the Rabble: An Intimate History of Gender and Power in the Age of Revolution, 1730-1830* (Chapel Hill: North Carolina University Press, 2006), 1, 187-8, 309.

the creation of societies and institutions intended to keep those who threatened to overwhelm the republic's cities and undermine the moral fabric of society hidden away.²⁹⁵ The dramas sparked by the Revolution were also played out in the theatre of the almshouse, and the female venereal ward was perhaps the most important stage.

Ten years after the 'Rogue's March', unrest broke out in the almshouse. Instigated by a group of women receiving treatment for venereal disease, they themselves declared to be participants in the 'Whoare's March'. In December 1789 'Insolent & Disorderly behaviour' was reported amongst the 'polishing room gang' of the venereal ward. Rachel Ward -the blind prostitute and frequent almshouse eloper encountered earlier- almost certainly participated in this drama. The target of the rebellious women was Jane Bickerdite, herself an ex venereal patient who had become a nurse of the ward and thus a representative of the almshouse authorities. She was 'discharged at her own desire' after the venereal patients 'quarrelled with and abused her very much'. According to Cummings,

...her best endeavours...not proving satisfactory to them...As she was going way ...They mob'd her severely and raised a Bawling Clamorous noise & Clanger with...Rattling Frying pans after her all of which together, they called the "Whoars March" and of which Doubtless they are competent judges...as every step they have taken for several years have been in line and true to the Beat.

The exasperated steward ruefully complained 'those insolent hardened Husseys go on dispensing all Rule & Order here'.²⁹⁶ Although this is an extreme expression of collective resistance, prostitutes and diseased women -like other members of the lower classes- frequently administered their own regulations, attempting to defy and undermine those who sought to use the almshouse as a coercive tool. As Gary Nash reminds us, the poor had their own rules, which were asserted to frustrate their betters.²⁹⁷ More than any other group of almshouse residents it was venereal patients who broke the rules on a continual basis. While the records reveal a great deal about attitudes from above, Cummings' notations are particularly revealing in highlighting how prostitutes interacted with the institution's officials and other women in a similar situation. This chapter will seek out the voices and attitudes of diseased almshouse

²⁹⁵ Gary Nash, 'Poverty and Politics'. 16.

²⁹⁶ 22 Dec. 1789, Dockets.

²⁹⁷ Gary Nash, 'Poverty and Politics', 19-20.

women in order to explore the ways they experienced and responded to incarceration. In addition, we will see how these women worked together as part of a prostitute community, one that overlapped with and may often have been fully integrated with the working class communities of Philadelphia, particularly Southwark. While many such women acted independently of friends or kin, many acted collectively, as seen in their 'Whoars March'. Relationships between almshouse women were formed in the venereal ward, stretching beyond the almshouse into the street where networks and friendships were formed, that sometimes intersected with the rest of the community. These networks of association -in the brothels, streets, and ale-houses of Philadelphia- clearly provided for collaborations between diseased women and prostitutes in the venereal ward of the almshouse.

3.1 Negotiating Incarceration

We have considered how officials attempted to control and extract deferential behaviour from diseased almshouse women, yet how did this group of poor relief applicants respond to measures of control? Recently, historians of eighteenth century America have faced a conundrum as to whether we can use the language of deference as a reliable framework for studying relations between the upper and middling sort and ordinary folk. According to Zuckerman 'deference is the essential term' in a new scholarly consensus, yet, 'it is a slippery term with a multitude of meanings.'²⁹⁸ Richard Beeman suggests that deference is a misnomer and instead proposes a model of 'varieties of deference'.²⁹⁹ As part of this larger debate, scholars have long recognized that almshouse inmates did not always acquiesce submissively to administrators' social control policies. While it would be simple to use the concept of deference as a framework of analysis to illuminate the response and behaviour of venereal inmates, some acts of resistance were more subtle than outright subversion. The range of inmate response does not fit a simple dichotomous model of control and resistance, or more specifically, deference. In a special issue of *Early American*

²⁹⁸ Michael Zuckerman, 'Endangered Deference, Imperiled Patriarchy: Tales from the Marchlands', *Early American Studies*, Vol.3, No.2 (2005), 233.

²⁹⁹ Richard Beeman, 'The Varieties of Deference in Eighteenth Century American', *Early American Studies*, Vol.3, No.2 (2005), 311-40.

Studies devoted to this debate, Gregory Nobles asked: ‘are deference and defiance really our only two options’.

Such limited, bifurcated choices offer us only a false dichotomy between protest and peace; they allow us too little opportunity to consider a wider and...more historically realistic range of human behaviors and social relations: just as people cannot live well in a condition of submission, they cannot live either well or long in a state of near-constant conflict... Instead, I think we can understand both deference and defiance better by exploring the subtler forms of interaction between elites and the lower classes and, above all, by thinking of those relationships in terms of an ongoing negotiation of power.³⁰⁰

The almshouse records provide further evidence that the language of “negotiation” as a middle ground between “deference versus defiance” provides a more comprehensive and more subtle framework. This conceptual net captures the strategies employed by a group of ordinary people who have not left us with their thoughts or first-hand account of their actions.

Gender historians frequently ground their arguments in a similar conceptual dichotomy, that of “agency versus passivity”. In the historiography of prostitution, recent trends have sought to retrieve women’s agency and power.³⁰¹ Yet in order to treat almshouse women as individuals in their own right, it would be more appropriate to demonstrate the variety of ways in which they negotiated and in the long run became full participants in the process of receiving public medical relief. The benefits of such an analysis include removing the dichotomy of “agency versus victim” usefully undermining the tendency to depict historical actors as homogenous groups.

³⁰⁰ Gregory H. Nobles, ‘Class Act: Redefining Deference in Early America’ in *Early American Studies*, Vol.3, No.2 (2005), 290.

³⁰¹ Two classic studies on the history of prostitution in English port and garrison towns adopted this concept quite heavily and both reached very different conclusions. Frances Finnegan locates the circumstances of prostitutes living in Victorian York. By examining Poor Law, newspaper and penitentiary records, she highlights how drink, destitution and disease characterised the lives of York’s prostitutes. Finnegan concludes that prostitutes were passive victims to male seduction and legislative oppression, who ultimately displayed minimal agency. Frances Finnegan, *Poverty and Prostitution: A Study of Victorian Prostitutes in York* (Cambridge: Cambridge University Press, 1979). Judith Walkowitz challenged this argument. Using the Contagious Diseases Act as a point of reference she mapped out changes in nineteenth century ideology, legislation and social policy pertaining to prostitutes, and finds women were not ‘the innocent victims of middle class seduction’ and made informed and rational choices in the face of limited economic opportunities. Judith Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1980), 13. Also see Marilyn Wood Hill, *Their Sisters Keepers, Prostitution in New York City, 1830-1870* (Berkeley: University of California Press, 1993); Christine Stansell, *City of Women: Sex and Class in New York, 1789-1860* (Urbana: University of Illinois Press, 1987).

While it is valuable to consider agency, by doing so we also obscure the structural economic and social inequalities that marked many women's lives both in terms of class and gender.³⁰² According to Linda Mahood 'the idea that women are passive objects of social policies is too simplistic'. Instead, Mahood proposes a model centred on indicators of women's choice and 'capacity' of agency.³⁰³ Mahood's discussion of Glasgow prostitutes is heavily theorised, emphasising the nineteenth century discourses of 'dangerous sexualities' with scant regard for individual experience. Yet, a discussion of women's *capacity* for agency does provide a more fruitful structure to locate the concrete realities and actions of diseased almshouse women. This chapter also attempts to address a gap in the historiography of poorhouse inmates. Newman and Smith point out,

Interactions among managers and inmates involved complex, nuanced negotiations. Historians have theorized the infra-politics and micro-resistance involved in these types of confrontations and compromises, but have been considerably less successful in specifying the day-to-day reality of these relationships.³⁰⁴

Moreover, we cannot forget that some diseased almshouse women were gravely ill when they attempted to secure a bed in the almshouse venereal ward. Their ability to negotiate would have been limited when confronting the almshouse officials. As we have seen, many diseased women simply did not have the economic resources to treat their disease in any other way than by relying on poor relief. Despite this, the overall picture that materialises is a vociferous and confident group of women who were often undaunted by the judgements made from those in positions of power. Many of the venereal women come across in the records as feisty, vocal and at times quite unpleasant. Not all women appeared at the almshouse with raucous determination, and not all women with venereal disease were prostitutes.

3.2 Arrival at the Almshouse: the Interview

A prostitute's first point of contact at the almshouse itself tells us much about what she thought about her role as a recipient of relief, especially in the narratives left by

³⁰² For a discussion of the historical constructions of women's autonomy or subordination see Linda Mahood, *The Magdalens: Prostitution in the Nineteenth Century* (London: Routledge, 1990), 12-14.

³⁰³ Ibid. 13.

³⁰⁴ Newman and Smith, 'Incarcerated Innocents', 4.

John Cummings the steward. A diseased woman had to first obtain and produce a recommendation or order from an upstanding citizen. This system became especially important to the managers in the years following American Independence in light of an apparent breakdown of the social order.³⁰⁵ For the diseased prostitute seeking health care, this required due respect and submission to civic and almshouse authorities. On the whole, most women did receive letters of recommendation. However, some gained entry without an order, a practice which did not go unnoticed. When Hannah Levy was first admitted in 1793 Cummings complained she was sent, ‘by one of the overseers from the N[orthern] L[iberties]...without an order contrary to Law, order or custom’. Sarah Clark was admitted ‘without [an] order or invitation’ although she was ordered ‘into the dark room until the further discretion of the managers’.³⁰⁶ By the turn of the century the reins were tightened in almshouse admissions, and whereas previously those deemed “unworthy” recipients of poor relief slipped through the net with relative ease, admissions were more strictly controlled.³⁰⁷ That said, during the initial stages of contact with the almshouse it would appear that the majority of women accommodated with the recommendation system. Most had precious little choice but to comply by a show of deference and respect at this juncture, thus securing admission.

For many however, this first hurdle in the almshouse experience was where the show of respect ended. When a woman arrived at the doors of the almshouse she effectively stood in the dock awaiting trial. And unfortunately for these women, John Cummings was her judge. The sarcastic disapproval articulated by the steward not only illustrates his opinions of this group of almshouse inmates, but also the kind of hostility diseased women confronted when seeking admission. The interview was often a relatively stage-managed event. Given the stigma attached to venereal disease it is understandable that many women hoped to conceal the true nature of their illness,

³⁰⁵ Accordingly to John Alexander, the Recommendation system ‘embodied the fullest ideal of deference’. *Render them Submissive*, 22, 167.

³⁰⁶ Hannah Levy, 12 Aug. 1793; Sarah Clark, 26 Mar. 1801; Ann Holland, 16 Mar. 1802, Dockets.

³⁰⁷ As noted, the sarcastic and anecdotal subjectivity so characteristic of notations in the 1790s gave way to more meticulous and impartial accounts of admissions- methodical and systematic in detail and less qualitative in nature. Moreover, officials were concerned first and foremost with their budgets, and displayed great determination in only allowing those with a legal residency through the almshouse doors

instead preferring to allege an ‘acceptable’ ailment.³⁰⁸ Cath Hayes declared she was ‘afflicted with Fitts’ yet Cummings ‘believed’ she was venereal. Until medically examined, the standard complaint of inmates was ‘sore limbs’. When Jane Dolly was questioned she claimed to be ‘inflicted with the Rhu[e]matism’, however when closer examination revealed the tell-tale physical signs of infection she later ‘owned up...that she hath the Venereal Disease’. Cummings noted that despite previously being treated in the infirmary, her ‘complaint or pretext’ was, in Jane’s words, ‘swelling in the limbs’. Similarly, when Jane Brady was admitted in 1794 she complained of having ‘pains in her limbs’ and Cummings noted that this was ‘commonly the first complaint made here by most of the dirty venereal hussys’.³⁰⁹ Susanna Doyle was a known prostitute who during 1791 acted as nurse in the venereal ward, in order to pay for her own treatment. She was discharged in November of that year and ‘sent to service’ only to be re-admitted again in December. On her admission, despite being known as a prostitute, she was permitted to enter the ward ‘on pretence of being Rhu[e]matic[k]’ much to the disgust of Cummings.³¹⁰ Yet, there was a shared understanding here between steward and inmate. Prostitutes and diseased women knew they had to formally recast their disease as morally acceptable as part of the negotiation. Some resisted even this token act and sought to walk through the doors of the almshouse, with a strong belief that they held a legitimate right to free medical care. For most however, there was a kind of social contract and each side acted accordingly. The steward knew he would have little choice but to allow diseased women access into the wards for treatment.

Others played the game differently and came up with more ingenious tactics in order to gain access to the hospital wards. Under the pretence of being a visitor, Jane Shiever ‘procured admittance to see her mother’. According to Cummings, once inside the almshouse she had the audacity to ‘introduce herself into the Polishing Room expecting she might remain there until she was a little polished over’. When

³⁰⁸ In a similar vein, Marilyn Blackwell shows how patients seeking charity relief in Vermont during the Progressive Era redefined their status, and ‘fashioned identities as the deserving sick’. Marilyn Blackwell, ‘The Deserving Sick: Poor Women and the Medicalization of Poverty in Brattleboro, Vermont’, *Journal of Women’s History*, Vol. 11, No. 1 (1999), 60-66.

³⁰⁹ Venereal disease did in fact affect the limbs, thus it is hard to tell if this complaint was an excuse or genuine. Infection also affected the joints, and many patients were noted in the hospital registers as being at once syphilitic and rheumatic.

³¹⁰ Cath Hayes, 21 Apr. 1790, Jane Dolly, 6 Mar. 1790; Susannah Doyle, 29 Nov. 1791, 9 Dec. 1791, Dockets.

Jane's subterfuge was uncovered she was removed from the almshouse, 'but she again soon returned' with a legal order of admission. A habitual inmate, Mary Carlisle was more than familiar with the routine. On one occasion the almshouse steward found her in the workhouse, yet she had somehow managed to enter without undergoing the formal admission procedure. Cummings lamented 'by what means she came in again is not known...but she has been in the House for some time past...employed in Spinning'.³¹¹

Some women embellished their circumstances with narratives emphasising passivity and even victim-hood, with the hope of presenting circumstances that were morally acceptable to the managers. When Cummings noted Catherine Seaman's admission he clearly found her story dubious. Pregnant and venereal, Catherine claimed she was married and that her mariner husband was at sea. When questioned on his exact whereabouts, she '*supposed*...it was about 8 months ago that the Ship sailed' and 'it was reported the said Ship was cast away, but [was] not yet confirmed'. Moreover, when asked about the details of her marriage, Catherine was unable to produce a marriage certificate 'having left it in town'. Cummings recognized this charade, noting 'by all appearances her story is very dubious and equivocal'. Catherine's account tells us much about how inmates understood their plight and endeavoured to negotiate, as best they could a place in the almshouse. By rhetorically playing down her independence, a woman was stripping herself of agency and inscribing herself with victimization.³¹² Such was the case with Mary Thompson who 'pretends she lost her family to small pox'.³¹³ In addition, by recounting a fictional illness or adding a dramatic and tragic dimension of abandonment, she bestowed herself with an acceptable background.³¹⁴ On the other hand, while some feigned the nature of their illness or presented themselves as the victims of circumstance, others did little to obscure their disease, and in fact were quite frank during the interview, perhaps to the point of attempting to shock those in charge. For Elizabeth Halden it was a means of

³¹¹ Jane Shiever, 5 Mar. 1797, Apr. 1793, Mary Carlisle, Dec. 1801, Dockets.

³¹² Catherine Seaman, 20 Feb. 1798, Mary Carlisle, 20 Sept. 1801, 20 Dec. 1801, Dockets.

³¹³ Mary Thompson, 4 Sep. 1795, Dockets.

³¹⁴ For similar conclusions in London see Kevin Siena, *Venereal Disease, Hospitals and the Urban Poor* (New York: University of Rochester Press, 2004), 206. According to Siena, 'patients constantly lied hoping to obtain treatment under the guise of an innocent disorder without having to enter the dreaded foul wards'.

avoiding the house of employment, and guaranteeing a bed in the hospital wing. According to the steward,

[she is] a very disorderly girl who for several years past has been confined to the Work House, but has always...ret[urne]d to her former lewd & disorderly conduct, and now complains of being Infected with the Venereal Disease, which renders her an Improper Object for the Work House.³¹⁵

A further strategy employed by diseased women during this phase of the almshouse experience was the use of multiple names in an attempt to remain anonymous and fool the almshouse official. The adoption of a different persona was (and still is) a common trick of the trade for women working in the sex industry.³¹⁶ Hannah Levy was well known to administrators by this name and occasionally went by the name Hannah Orr, clearly in an attempt to fool a different official. She was admitted upon every application that we know of. Others created entirely different aliases. Hannah Sharp was admitted to the venereal ward under this name in 1790 and 1797, yet in 1798 she returned under the alias Mary Smith, and once again secured a bed.³¹⁷ By fashioning a new identity, some prostitutes were creating a distance between their public professional life and their private one. In the public realm, these women were essentially “for hire”, yet they could also be the wife, mother, daughter and friend of others outwith the role of prostitute. Being economical with the truth in relating personal circumstances did not necessarily signify an unwillingness to reveal that their way of life was shameful. Rather, it may have been a diseased woman’s way of manipulating officials and take control of their situation.³¹⁸ To this end, there seems to have been an unspoken and un-codified agreement between officials and venereal patients. This involved initial compliance whether real or feigned. Some women

³¹⁵ Elizabeth Halden, January 1798, Dockets.

³¹⁶ The issue of prostitutes’ using nicknames came to the public forefront during the murder trial of New York prostitute Helen Jewett during the 1830s. The initial stage of the investigation was hampered given that Jewett had used numerous aliases throughout her career to the extent of re-fashioning her previous life, making the job of tracing the roots of the murder victim near impossible for police. Newspaper editors ran riot with the story, with a host of conflicting accounts on the background of Jewett being published. Cohen, *Murder of Helen Jewett*, pp.39-47.

³¹⁷ Hannah Sharp, Mar. 1790, June 1797, Mar. 1798, Hannah Levy as Hannah Orr, Mar. and Oct. 1800, July 1801, Dockets.

³¹⁸ It has been suggested that indigents shaped the welfare system in Philadelphia outlying regions to suit their own needs in a process where administrators shifted negotiations with inmates. Monique Bourque argues that both overseers and inmates understood ‘that both aid and authority had limits’ and both groups worked with this assumption. Monique Bourque, ‘Poor Relief Without Violating the Rights of Humanity: Almshouse Administration in the Philadelphia Region, 1790-1860’, in Smith, *Down and Out*, 189-211.

humbly submitted to those in charge in order to obtain admission. Others, comfortable in the knowledge they enjoyed a fundamental right to relief, made a more brazen appearance at the doors of the almshouse.

3.3 Behind the Walls

After a woman with venereal infection was admitted she would normally be kept in the venereal ward until deemed “cured” by the physician. Treatment could last from a matter of days to around five months depending on the severity of symptoms. In 1797 for instance, diseased women underwent an average of five weeks of treatment in the almshouse. Length of treatment often depended on when a woman deemed herself fit to leave, regardless of a physician’s order recommending ongoing treatment or her discharge. Although staggering numbers of women eloped before they were deemed well enough, as many endured the full course of treatment and were re-admitted time and again when their symptoms returned.

During her course of treatment, a woman was not made to work and she was kept resting in the venereal ward. While conditions may have been grim -like any other poorhouse hospital during the period- physicians campaigned tirelessly for the care of both male and female venereal patients. Once a woman’s therapy ended, a physician would sanction her removal to the convalescent ward for recuperation. Thereafter, once she was, ‘discharged from the Sick List...be kept on a Diet of Bread and Water...and kept at work according to ability in the house of employment’.³¹⁹ It was usually at this juncture of the almshouse experience when women eloped, and an overwhelming number left with relative ease after receiving sufficient healthcare to allow them to return to their daily business.

³¹⁹ Dec. 1788, 17 Jan. 1803, M.M. For specific details on therapy see chapters five and six.

Year	Female Venereal Admissions (n=)	Elopements (% of total venereal inmates)
1790	20	30
1791	35	46
1792	36	51
1793	54	22
1794	31	48
1795	26	46
1796	33	67
1797	42	29
1798	36	67
1799	40	60
1800	55	27
1801	60	16
1803	55	33
1804	53	26
1805	52	15
1806	70	18
1807	99	34
1808	107	40

Table 4, Female Venereal Elopements, Philadelphia Almshouse

Source: Guardians of the Poor, Daily Occurrence Dockets 1790-1840; Admission Register 1800-1806; Female Receiving Register, 1800-1806; Almshouse Admission Book 1785-1827; Apothecary's Register of Sick and Surgical Ward Patients, 1800-1803; Weekly Return of Patients in Sick and Surgical Wards, 1805 and 1807.

According to Clement, venereal patients 'were certainly no more likely to abscond than healthy, normal or even deranged patients'.³²⁰ In actual fact, venereal inmates- both male and female- had a greater tendency to elope than any other group of sick patients. They were certainly more likely to escape than those patients being treated for insanity, or any other disease for that matter. Of a total sick population of 2002 inmates during the twelve month period from May 1807, patients with venereal diseases figured prominently amongst those who absconded: 59 percent of sick escapees had venereal disease. A further 24 percent had been treated for 'ulcers', some of which may well have proved to be venereal ulcers had the patient waited long enough for assessment and/or treatment. Only 2 percent of those who eloped were

³²⁰ Clement, *Welfare and the Poor in the Nineteenth Century City: Philadelphia, 1800-1854* (Rutherford: Farleigh Dickenson University Press, 1985), 109.

‘deranged’. Moreover, as revealed in Table 4, 34 percent of all female venereal patients left prematurely.³²¹ Diseased men also eloped yet their numbers were always lower when compared with female elopements. In fact, the majority of sick male elopements were by men being treated for ulcers.³²²

	Admitted	% of Total Venereal Admissions	% of Total Venereal Admissions who Eloped	% of Male and Female Elopements
Male	47	32	5 (n=7)	11 (n=7)
Female	99	68	23 (n=34)	34 (n=34)
Total Venereal Admissions	n=146	Total Venereal Elopements	n=41	

Table 5: Almshouse Venereal Inmate Elopements, 1807

Source: Guardians of the Poor Alms House Hospital Weekly Return of Patients in Sick and Surgical Wards, 1807

Clement also suggests that before the 1820s ‘escape over or through the dilapidated Bettering House [almshouse] fence was relatively easy, very few inmates absconded, probably because they had little reason to do so’.³²³ It is true that at times elopement figures were somewhat quite low: amongst venereal patients between 1800 and 1803 for example, relatively few took to their heels. However, as Table 5 illustrates, the percentage of women who eloped each year remained relatively high throughout the 1790s and the first decade of the nineteenth century, despite some dips during the turn of the century. Between 1790 and 1799, an average 54.5 percent of female venereal admissions absconded before being given an official endorsement of discharge. Clement does take note of this, observing that they had an ‘extraordinarily high propensity to flee’. She claims that this was at a later date, when a meagre 7 percent escaped in 1812-13, a much lower figure than during the first couple of decades of the new nation’s existence.

³²¹ This was used as a sample year given that this period has the richest sources with which to cross-reference other registers with.

³²² Weekly Return of Patients in Sick and Surgical Wards, May 1807- May 1808, M.M.

³²³ Clement, *Welfare and the Poor*, 109.

Interestingly, after the almshouse relocated from 1835, a greater number of venereal inmates escaped than had previously been the case. On the one hand this is surprising given that the institution was moved from its previous site where inmates had been able to ‘simply scale the fence and walk across Spruce Street to a bar.’ Patients who fled the new Blockley Almshouse had to navigate farmland and cross a river several miles from the heart of the city. Thus, as Clement notes, ‘the huge imposing buildings situated well away from the city proper were intended to frighten the poor into doing all they could do to avoid incarceration’.³²⁴ Yet despite a higher fence and more rigorous surveillance of inmates, the later period points to an unexpected rise in the earlier patterns of elopement. We would assume elopement rates to drop significantly given the instillation of obstacles serving to thwart escape. Yet in light of more consistent and punitive regimes it is little wonder inmates chose to escape before official discharge. Therefore, in the earlier years pertinent to this discussion, the almshouse seems to have served many of Philadelphia’s poor very well indeed. The fact remains that while venereal inmates did elope in large numbers, they kept returning.

According to Clement, between 1828 and 1850 ‘most VD victims had never used the institution before’.³²⁵ This contrasts sharply from data from the earlier period, which point towards a significant number of women being re-admitted.³²⁶ Again, in the period from 1812 to 1818 for example, 57 percent of female venereal admissions were re-admitted patients.³²⁷ This suggests that when the almshouse was located on Spruce Street, women could become familiar with the layout of the building and learn the strategies of almshouse survival, realizing that institutional welfare could serve them very well. Many diseased women that eloped then returned did so habitually. Cummings expressed utter exasperation over this, and the steward waxed furiously about diseased prostitutes coming and going at their apparent pleasure, having received only the minimum of treatment. For example, Patty O’Craft ‘sailed forth again only a little mended’ while Nancy Mcollister brazenly ‘appear[ed] for

³²⁴ Ibid. Clement calculates that for the period between 1828 and 1850, the proportion of elopements amongst venereal patients compared with the total almshouse population was 52 percent.

³²⁵ Clement, *Welfare and the Poor*, 202, footnote 59.

³²⁶ Not all of those women eloped; many returned after they had previously paid off their treatment.

³²⁷ Guardians of the Poor Philadelphia Almshouse Hospital Weekly Census and Admissions, 1812-1828. Calculations are taken from a database of 468 patients. 265 were re-admissions, and 203 patients used the almshouse only on one occasion.

polishing'. Mary Carlisle was a particular thorn in the side of administrators. In February 1794 she was discharged by the doctor, and according to Cummings she was 'somewhat relieved thinking herself fit for business again'. Mary was admitted again in June in the 'foulest...diseased' condition, yet after medical aid she eloped a few weeks later 'well bottomed but not thoroughly repaired'. Therefore, even the most hardened prostitutes were readmitted. When Ann Barber escaped, it was noted the 'vile little dirty hussy has absconded again...but will soon be back so need not be counted gone'.³²⁸ Evidently these women understood the almshouse to be a resource they could utilise periodically for recuperation on their own terms, with little in the way of respect for administrative authority and procedure

Women used the almshouse not only to gain medical treatment but also to receive an income in the outside world. When the diseased Irish woman Margaret Bailey was admitted, it was noted in the Receiving Register that 'this woman who has been coming and going in this House...stole her medicine and shifts at her last departure when she eloped'.³²⁹ From 1797 to 1807 Margaret Bailey was re-admitted at least nine times. Often she herself applied for help, however on some occasions she was brought from jail 'always in a deplorable condition', and on one occasion she was 'so ill from the venereal disease' that she could not appear before magistrates for a charge of theft.³³⁰ Margaret used the almshouse with seeming ease, always presenting herself as a force to be reckoned with. Margaret's husband was a sailor and she clearly lived in dire circumstances, often being arrested for stealing. For her, the almshouse simply kept her alive, not only with medicine for her venereal afflictions, but also with life's basic necessities. Margaret behaved badly, yet she simply knew how to manipulate those in positions of authority, retaining a measure of independence in her life. However badly she behaved, she was always granted re-admission. In fact, while the almshouse was supposed to aid the 'worthy' poor and sick population, women who broke rules were rarely turned away. Many diseased women simply learnt how to take control of and manipulate the system. Prostitute Margaret Mclean is another good case in point. In November 1794, Cummings entered her in his dockets as a

³²⁸ Patty O'Craft, Mar. 1796; Mary Carlisle, Feb. and June 1794. Ann Barber, 19 Apr. 1790, Dockets.

³²⁹ Margaret Bailey, Weekly Return of Patients, 1805.

³³⁰ Margaret Bailey, Mar. 1797, Aug. 1800, Jan. 1801, Nov. 1801, Nov. 1802, Mar. 1804, July 1804, Feb. 1805, July 1807, Dockets.

Noted impudent idle hussey, mostly here but often to and fro, on complaint of a bad sore leg-yet can at any time scale those fences, carrying out bedding, Cloathing or in short anything to purchase or procure Rum, which she easily & safely brings in and Divides with old Fleck the Baker who keeps her with himself almost continually Drunk in the Bake-house...she there shamefully idles her time.³³¹

Margret was wise to shoddy administration amongst officials and she collaborated with the baker, a representative of those in charge. The steward was disgusted that she was able exploit the almshouse's resources to such an extent that she sold its goods in the outside world. Consequently, he suggested that 'she ought not to be taken in here again on any account or pretence'. Yet Margaret was still using the almshouse for several years thereafter despite Cummings' recommendation that she should not be re-admitted. She secured a bed in the infirmary on a further four occasions and during one of these she was 'delivered of a son'.³³² It is not clear if this was the aforementioned baker's child. Some women also used the almshouse to ply their trade or simply for sexual encounters. Sometimes these were not with fellow inmates but with almshouse officials. The consequences of such encounters sometimes bore a heavy sting. In 1790 Mary McCulloch, a venereal and 'noted body' had sexual relations with the senior apothecary, Thomas Espy. It is not clear if money was exchanged, but thereafter Mary bore a son to Espy. The steward was riled that patient and official had sexually collaborated, and that Espy had since been committed to jail and was likely to be 'insolvent'. Cummings lamented that 'this institution (as common) must bear the burden of supporting and providing for her & hers'.³³³ Although an extreme case, prostitutes clearly found a ready clientele inside as well as outside the almshouse.

Clement's assertion that many inmates had little reason to abscond is an important point worth considering. Although almshouses have usually been presented in a negative light, the fact remained that some inmates were destitute and did not return to comfortable homes anyway as many were no doubt homeless. Brothel madams often turned out diseased women who found themselves both ill and homeless. For the many lower class streetwalkers who consorted with clients in dram-shops and taverns, they may have done so because they resided in lodgings too poor to serve as brothels.

³³¹ Margaret Mclean, 10 Nov. 1794, Dockets.

³³² Margaret Mclean, July 1795, Mar. 1796, Aug. 1796, Nov. 1797, Dockets.

³³³ Mary McCulloch, 3 Feb. 1790, Dockets.

The almshouse may have served as a home-from-home for such women. There was also the added incentive of free meals and clothes, with access to alcohol and medicine. The almshouse served a dual function for some diseased women for it was at once refuge and healthcare provider. This suited many women, who used the institution's resources as and when they needed.

The case of Sarah Burton is particularly illuminating for its typicality in demonstrating how many women selected and utilised the medical resources provided at the infirmary. Twenty-year-old Sarah first appeared in the record in February 1802. She was already familiar with the almshouse and its facilities given that four years prior to her first admission she had 'lived with William Laing our Gate-keeper'. She was now married to Henry Burton, a 'drunken ordinary sailor who went to sea 4mos ago in the ship Experiment'. Sarah probably struggled to make ends meet with her earnings from the city hospital while her husband was at sea, and she may have engaged in prostitution. Alternatively, she may have caught the disease from her husband or a previous partner. When Sarah first arrived at the doors of the almshouse she appeared 'sick and diseased', stating she had great pains in her legs although she also claimed did not know the nature of her illness. However, it was noted that 'she has a breaking out on her Nose and face...probably the venereal disease'. Sarah endured six weeks of treatment, during which time she presumably made herself more familiar with the layout and medical routines of the institution. When she was next admitted in June she stayed only a couple of weeks before eloping. A month later she again managed to secure therapy and this time she stayed for only three weeks of treatment before she absconded over the fence. By this time Sarah was very ill from the effects of syphilis. She had lost her job as nurse at the city hospital, and on her only official discharge she had been sent to work as a domestic servant by the managers. On her third admission in November Sarah returned with 'her old complaint sore legs'. This time however she was so ill that she had to endure six months of treatment until May when she was officially discharged this time. The following month she once again 'returned...this time with asthma and a sore throat'. In November 1803, after three months of further treatment Sarah died, and her last

entry recorded by the clerk or new steward noted, 'a young woman...sick with asthma and sore throat and lingered on till now'.³³⁴

There are several important factors to consider here. Like many women already mentioned, Sarah learned how to play administrators in order to gain admission, yet she did not appear as brazen as some others in her position. She fashioned a palatable identity for the almshouse administrators, and emphasising her passivity Sarah presented herself as abandoned and desperate. She framed her husband as a worthless drunk who had likely infected her, using this as a bargaining tool to secure her many admissions to the infirmary ward. Importantly, the records were actually written in a manner that downplayed her agency, thus those 'above' accepted her self-representation as victim. Sarah no doubt played upon this strategy. It is likely that she already knew she was diseased upon her first admission given the state of her face when she arrived at the almshouse doors. Presumably she had been treated elsewhere for venereal infection no doubt with mercury (which would explain the condition of her face and particularly her nose) before seeking almshouse aid. Sarah treated almshouse medical therapy as if it was free and there for the taking. Given her previous relationship with the gate-keeper, it is likely Sarah knew how simple it would be to access minimal treatment and avoid payment. Once she became familiar with the nature and routine of the treatment available (including alcohol as a medicinal) and importantly how relatively easy it would be to secure what she believed was the right amount of therapy, she eloped. To an extent, Sarah became a customer and resident, rather than an inmate. She repeated the procedure several times. What Sarah may not have realised was just how sick she actually was, and like many other young women she spent her last days in Philadelphia's almshouse. As we shall see, the medical profession were unclear both about the nature of the disease itself and were also often at odds on how best to treat it. Sarah may actually have believed (like Cummings and presumably the medical department) that she was cured of venereal infection after her short bouts of treatment. On her last discharge in the admission and deaths, no mention was made of venereal infection, and death was recorded as being caused by asthma.

³³⁴ Sarah Burton, 6 Feb. 1802, 9 July 1802, 2 Aug. 1802, 10 Nov. 1802, 17 May 1803, 17 June 1803, 19 Oct. 1803, Dockets; Admissions and Discharges, 1785-1805; Female Receiving Register, 1800-1806.

A common thread links Margaret Bailey, Margaret Mclean and Sarah Burton. They all took to their heels on more than one occasion when they believed that it was time to go, yet they returned, often several times, safe in the knowledge that they would be re-admitted. Diseased women such as these took full advantage of lax organization, and however much they abused the system by escaping on a regular basis, they normally managed to acquire a further recommendation for admission. With money to be made on the streets, many were most likely seeking a quick-fix solution to their afflictions in the hope of making a speedy return to the job. The almshouse was also an alternative to poverty during a slump in business. From spring until the autumn ships sailed into dock and the city's prostitutes were provided with readily available custom from a group of sailors with money in their pockets. In winter, such clients were harder to find.

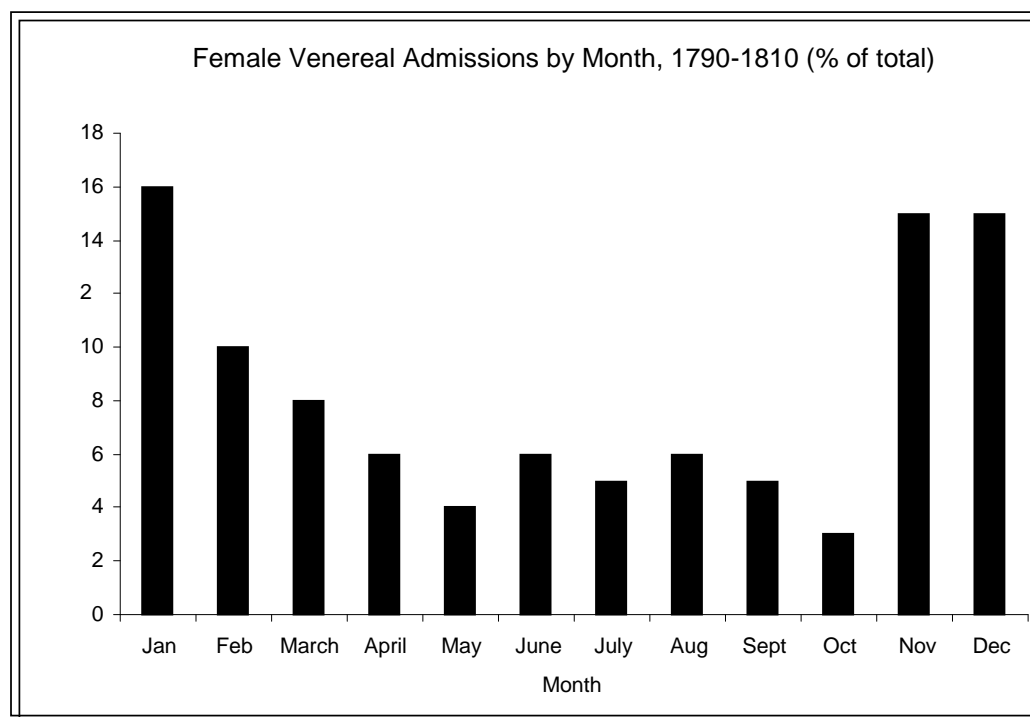


Table 6: Seasonal Use of the Almshouse.

Source: Daily Occurrence Dockets 1790-1820; Admissions and Discharges 1785-1827; Apothecary's Register of Sick and Surgical Ward Patients, 1800-1803.

Table 6 illustrates seasonal patterns of use by diseased almshouse women, and the results are not surprising. We would naturally expect any poor person to seek shelter in an effort to survive the winter months. Philadelphia's winters were harsh, and this encouraged paupers' utilization of almshouse resources. Here they were provided with food, clothing and importantly fuel. Mary Carlisle often took up residency when the weather turned (as did other almshouse inmates). In January 1803 she was admitted and noted as 'well known...but at present is not diseased'.³³⁵ Carlisle simply needed shelter and warmth on this occasion. When custom declined at the end of the autumn, we see an exceptionally rapid increase in women seeking relief, with a rise from 3 percent in October to over 15 percent in November. This remained consistent throughout the winter until the weather improved and the ships sailed. Moreover, a closer look at the evidence reveals that during the summer months the women who sought treatment were often in far advanced stages of disease. In June and July 1794 for instance, seven women arrived at the almshouse for medical assistance. Five were noted as either 'very far advanced in the disease', 'highly diseased' or in the 'foulest venereal condition'.³³⁶ A 'negro woman' simply known as Grace, was recorded as 'highly venereal and far past all medical aid and died this evening'. None of the remaining women eloped, which suggests they were too ill to even contemplate navigating their way out the building and over the fence. In winter, diseased women who were not badly affected by infection often sought admission to the almshouse, whereas in summer it was often the most diseased and ill women who needed admission and treatment.

If prostitutes were deemed the unworthy poor, why were they permitted to seemingly abuse and take advantage of the system? Although prostitution was generally accepted as part of the city's social landscape, prostitutes were nevertheless deemed a nuisance. Inside the almshouse the numbers of venereal women seeking aid rose to such an extent that by 1808 the managers imposed a separate syphilis ledger for the

³³⁵ Mary Carlisle, 6 Jan, 1803, Dockets. Medical knowledge about the treatment of gonorrhoea and syphilis fell short of understanding that latent periods of infection were not in fact a sign of cure. Thus, when inmates were discharged as 'cured' doctors believed they actually had been restored to health. Any future sign of disease was believed to be re-infection, and not a manifestation of the original infection. This will be attended to in chapters five and six.

³³⁶ Mary Carlisle, 6 June 1794, Hannah Levy, 1 July, 1794, Priscilla Wilson, July 1794, Martha Peters, 23 July 1794, Isabella Donnahoe, 30 July 1794. Grace, 21 July 1794, Dockets.

charge of each venereal patients care, both male and female.³³⁷ They ordered the steward to ‘open an account against every person...charging...board, clothing, medicine, medical attendance and every other expense that may accrue’.³³⁸ It was a fruitless plan, which was quickly abandoned by officials. Although stricter regulation of venereal patients could not be executed effectively, this strategy nevertheless shows that the managers were attempting to rein in this group of almshouse inmates who were perceived as a consistent drain on economic resources.

A record was kept of cost accounts for all almshouse inmates, sick or not. In 1807 the cost of almshouse care for female venereal patients ranged between \$1 and \$24. Two separate accounts existed for each woman: one for medicine and the other for alcohol for both recreational purposes or as a key medicinal ingredient.³³⁹ Often a woman’s alcohol bill exceeded that of her medicine. Rachel Evans was admitted in January 1807 with an ulcer found to be gonorrhoeal. Clearly Rachel suffered great pains from her ulcers, racking up a total bill of \$33.88 for a three month stay and \$21.75 of this was spent on alcohol. Not surprisingly, when ‘relieved’ of her ulcers, Rachel eloped rather than settle her bill, either by payment or work. However, six months later when Rachel returned, she was admitted again under the pretence of having a ‘sore leg’. Of 99 female venereal admissions in 1807, 22 women incurred bills greater than ten dollars.³⁴⁰ Of those women three died, and of the remaining 19 inmates, nearly half eloped in order to avoid payment or forced employment. Yet many of those women were readmitted time and again. Cummings was well aware that numerous women escaped simply to dodge their bill. Ann Gallagher, ‘a noted venereal runaway’, was ‘often in and out with the disorder’. Ann eloped on three occasions, and according to the steward, each time she absconded it was as a means of ‘avoiding payment’.³⁴¹ Yet Ann, like so many others was re-admitted despite continually avoiding payment.

³³⁷ If payment could not be made, inmates were forced to work for their pay in the House of Employment wing of the almshouse.

³³⁸ Guardians of the Poor, Syphilis Ledger 1808, PCA.

³³⁹ As we have already seen, venereal inmates were included amongst those rewarded for good behaviour. 24 Feb 1806, 22 July 181 19 Feb. 25 Sep. 1821, M.M.

³⁴⁰ Weekly Return of Patients in Sick and Surgical Wards, 1807; Guardians of the Poor, Almshouse Hospital Department and Ward Census, 1807, PCA. Guardians of the Poor, Inmates Boarding Accounts, PCA; Guardians of the Poor, Almshouse Hospital Apothecary’s R x Cost Per Inmate (1805-1806), PCA.

³⁴¹ Ann Gallagher, Jan. Mar. Dec. 1793, Mar. 1794, Mar. 1796, Dockets.

There is no obvious reason why inmates like Ann were allowed to re-enter the almshouse so easily. Clearly, officials had to keep a check on the spread of disease. And like the countless numbers of vagrants brought before city magistrates, visible and diseased prostitutes simply had to be removed from the public sphere. Historians have described the relatively small size and intimate nature of Philadelphia during the early national period. Venereal patients may indeed have solicited sympathy for such a gruesome and often disfiguring disease, even from those members of society who otherwise scorned them. This was the case with the steward, who displayed both antipathy and sympathy towards venereal patients. Moreover, venereal disease was not class specific and the better sorts fell victim to sexual diseases and were therefore often familiar with its ramifications.³⁴²

Moreover, paupers were needed to keep the almshouse functioning. Once a patient was relieved of his or her ills, ‘inmates themselves kept the institution running: they did the cooking, baking, butchering, painting, gardening, washing...[and] watched the cells’.³⁴³ They also tended to the sick as was the case with ex-venereal patients Susannah Doyle and Jane Bickerdite the nurse who was hounded out the polishing room by a fresh round of venereal patients. Inmates were also used as cost-effective resources, supplying the house with a host of cheap goods that helped to keep the institution functioning, particularly through their work in the House of Employment. The Managers’ Minutes, Daily Occurrence Dockets and Treasurers Weekly Entries testify to ongoing connections between the steward and numerous inmates who supplied the house with items ranging from flax (for spinning and weaving) to tin, copper and other junk materials. This we saw in the economic transactions between the steward and Rachel Ward, a known prostitute. Despite the caustic language directed toward her by Cummings, he was nevertheless content to compensate for her services. The almshouse served an important manufacturing role, and once a patient

³⁴² The best account I have found presenting a first-hand perspective of the disease from a Philadelphian ranked from the better sorts is amongst the letters of correspondence of the Chew family already noted above. The papers are held in the Historical Society of Pennsylvania. A different, more ‘comical’ (although equally illuminating) account is the 1790s journal of a Philadelphia man drawn from the middling sorts who kept his accounts in the lawyer James Wilson’s diaries. As a result of his apparent copious sexual encounters, he contracted venereal infection, complaining, ‘Clapp-much itching in my flopper-must keep away from my wife’. James Wilson, Account Book and Diary, American Philosophical Society, Philadelphia. This also illustrates that some men were not surprised when infected, and indeed treated it as a normal occurrence.

³⁴³ Clement, *Welfare and the Poor*, 88.

was signed off the sick list and discharged to the convalescent ward or house of employment, he or she was expected to work for their keep in the factory. For women, the most common work programme ascribed to them was picking oakum although they were also expected to engage in spinning and weaving. Inmates were often rewarded for hard work in the form of extra cash or alcohol for example. Diseased ‘frequent customer’ and habitual eloper Mary Golden gave the managers and superintendents no end of grief, sometimes finding herself confined to the cells when intoxicated.³⁴⁴ But on occasion she was rewarded ‘for good Conduct and orderly Behaviour’ and was furnished by the steward with ‘useful articles of Cloathing’ and ‘one Dollar’.³⁴⁵ Therefore, even those inmates with venereal disease were included as part of a wider marketplace community that kept the house ticking over with a constant supply of goods and services. Paupers were no doubt aware of their profitability to the House, that their work or supplies of goods were necessary. This may have created a kind of social contract between those above with those below. Inmates recognized their ability to manipulate an ongoing economic relationship between themselves and the almshouse.

Furthermore, given that the proportion of almshouse employees in a supervisory role (clerks, apothecaries, steward, gate-keeper, matron) was always marginal compared to the numbers of inmates, they had to be vigilant about how they wielded their authority. Therefore, as Clement claims, ‘the poor may have enjoyed considerable freedom’ inside the almshouse.³⁴⁶ To this end, poor Philadelphia residents who used the almshouse for relief in fact played an important role in shaping the system itself, and used it for their own gain, safe in the knowledge that officials needed them. For the

³⁴⁴ Mary was sent to the cells for relentless bad behaviour while under the influence of alcohol. Inmates brought under lock and key were recorded in the Black Book. Although the almshouse did inflict punishment, the cells were used primarily for the purposes of detaining deranged inmates. Most instances when inmates were punished involved those who were discharged upon the promise of return, subsequently to be found drunk in the street. The names of diseased women appear in the Black Book although they appear more than other inmates. Mary Golden, 14 March, 1814. *Guardians of the Poor, Philadelphia Almshouse Black Book, 1810-1814*, PCA.

³⁴⁵ 25 Mar. 1801, M.M. For other examples of prostitutes being rewarded for good behaviour see 12 Nov. 1797, M.M. Mary Golden continued as a disruptive force throughout her various admissions until her last discharge. In 1827, a Hannah Foster wrote to the mayor and judge Joseph Watson, ‘desirous of obtaining proceedings against Mary Golden, as a disorderly bawdy housekeeper’. While it is unclear if this is the same woman, Mary does not appear in the institutional record again after her last almshouse admission, so there is a chance this is the same woman. See Joseph Watson Papers, Historical Society of Pennsylvania, 25 June, 1822.

³⁴⁶ Clement calculated that between 1807 and 1826, there was one employee for every seventy-five inmates. Clement, *Welfare and the Poor*, 88.

most part women came to the almshouse voluntarily (in theory they were to be held there until officially discharged, yet in practice they could not be detained against their will). As we shall see in the next chapter, diseased women acted as customers rather than inmates, selecting the almshouse as one choice in the wider medical marketplace of Philadelphia. I would go one step further than Clement, and suggest that the late eighteenth and early nineteenth centuries present a moment in time when venereal inmates -while perhaps not exactly running the show- certainly exercised considerable agency in negotiating almshouse care. This was of course dependent on the nature of the person dealing with a diseased woman's application and confinement, whether an overseer, manager, steward or physician. While on the one hand, diseased women were reliant on almshouse officials, and initially obeyed them, they were also fully aware that officials had to admit them. The relationship between diseased women and almshouse officials was a subtle reciprocal one. Accommodation and adaptation became important bargaining tools, and the tricks women learnt for dealing with officials came from other women in a similar situation.

3.4 Communities of Prostitutes

Communities of diseased almshouse women hailing from geographically separate areas of Philadelphia converged in and formed bonds within the almshouse, and these relationships were then maintained on the streets. Newman notes that 'the almshouse provided a means to continue living life on the streets as best they could'.³⁴⁷ Among no group of almshouse inmates is this better illustrated than the female venereal population. Anthropologists and sociologists have emphasised that becoming part of a subculture helps people cope with difficult life circumstances and working conditions.³⁴⁸ For prostitutes, becoming part of a distinct community helped women adapt to the tough encounters specific to their work, and the ability to draw upon various networks also provided valuable protection.

The sources capture the various formations or associations consolidated by diseased women, particularly in the context of "space" or "neighbourhood" as they intersected at, and extended beyond, the city's public institutions. Although many of those

³⁴⁷ Newman, *Embodied History*, 38.

³⁴⁸ Maggie O'Neil, *Prostitution and Feminism: Towards a Politics of Feeling* (Blackwell: Oxford, 2001), 28.

women were considered deviant by some, they were often part of a larger culture of poverty, and rubbed shoulders with others belonging to similar groups yet hailed from disparate areas.³⁴⁹ The evidence suggests women moved from their own neighbourhoods to work in other districts where their almshouse companions had come from. By aligning themselves to another subculture, or “community of prostitutes”, almshouse women may have inscribed themselves with a social identity. This served to encourage or support women to draw upon the medical resources from the almshouse. The social ties made through these networks were vital for providing diseased women with knowledge and resources to either accommodate with or resist the efforts of officials to circumvent their activities.

Inside the almshouse, diseased women acted collectively in resistance, implying they were part of a distinctive community of prostitutes. This helped shape their experience of the almshouse, and it would be a fair assumption that once inside the venereal ward, women actively sought acquaintances. This would help cope with institutional confinement, and perhaps provide protection in the street after discharge from the almshouse.³⁵⁰ Networks of association cultivated inside the almshouse were at play during various stages of the institutional experience, particularly when a woman chose to leave. Female venereal inmates often slipped away collectively, usually in groups of two, and some were crafty in their escape. Mary Golden and her companion Jane Bigley waited until the rest of the inmates were dining in the communal area and slipped out unnoticed.³⁵¹ Many diseased women from the same districts of Philadelphia consorted together inside the almshouse. The Vagrancy Dockets reveal the existence, and indeed the nature of these formations as women were arrested on Philadelphia’s streets along with the same companions who had acted together in the almshouse. In 1796 Margaret Powers jumped the fence along with Sarah Evans. A year later, Cummings reported that Sarah had eloped along with two others from the ‘polishing room’ and all were from the same area of Philadelphia. In 1798, Evans joined Mary Allen, a ‘companion and consort’ and together they

³⁴⁹ This analysis is made possible by the existence of partially traceable biographies, which can be connected through the records of different institutions with the use of computer linkage. Yet, this methodology has its limitations. In the early national period it is only possible trace those who came into contact with the public authorities. A later period would allow for a richer interpretation with the use of more detailed census material and private philanthropic records.

³⁵⁰ This would also serve as a way to make contacts with other streetwalkers, or to attract new clients.

³⁵¹ Jane Bigley and Mary Golden, 13 May 1798, Dockets.

scaled and jumped the fence. Evans and Allen hailed from the Northern Liberties area of Philadelphia, a particularly disorderly part of the city that was home to many prostitutes. It is likely that the women knew each other from the streets, taverns or brothel households of that district prior to almshouse admission. Often they were arrested for being ‘drunk and disorderly...lewd girls’ and ‘abandoned prostitutes’. Mary Carlisle whom we encountered earlier was another of Sarah Evans’ companions.³⁵² Yet Mary was in fact from Southwark, the part of Philadelphia that was furthest from the Northern Liberties. However, Mary was often arrested with companions from the Northern Liberties district. It is possible that Sarah Evans introduced Mary Carlisle to this neighbourhood after the two first met in the almshouse. A similar situation was apparent between almshouse women Phoebe Lewis and Mary Watson who were arrested together for being ‘idle vagrants’ in 1805. Although it is not clear where in the city they were arrested, Phoebe originally came from the Northern Liberties while Mary was from the city proper. It would appear that they established a connection with in the almshouse five years prior to their arrest.³⁵³ Thus, during various admissions to the almshouse, diseased women formed friendships and created new networks with counterparts from different areas of the city.

These relationships continued after departing the institution. Diseased almshouse women appear to have moved from their own neighbourhoods to work in districts that their almshouse companions hailed from. In a city that was overcrowded and characterised by transience, they would easily blend into their new environment. Such women could lead normal daily lives similar to, and alongside, their neighbours within the larger culture of their neighbourhood. Prostitution in early national Philadelphia had a quite public, urban character, similar to that of mid-nineteenth century New York.³⁵⁴ Neighbourhoods throughout Philadelphia’s rough and

³⁵² Sarah Evans, 13 Mar. 1796, 6 Apr. 1797, Mar. 1798, Dockets, Margaret Powers, Mary Allan and Mary Carlisle, 17 Nov. 1791, 7 Apr. 1792, 23 Apr. 1794, 13 June 1794, 17 June 1795 Dockets; Mary Carlisle and Sarah Evans, 4 August 1795 Vagrancy.

³⁵³ Pheobe Lewis and Mary Watson, Jan., Mar., Aug., 1800 Dockets, 30 Aug 1805, Vagrancy.

³⁵⁴ Stansell and Gilfoyle have shown how prostitution assumed a new context by mid-century with sites dedicated for sexual exchange becoming more public. Bawdy houses were no longer the reserve of lower class neighbourhoods, and were now more organised and located in cosmopolitan thoroughfares. This happened earlier in Philadelphia during the late eighteenth century, where prostitution was both informal (casual) and organised (in the specific bawdy houses located throughout the city). Gilfoyle,

respectable districts catered to prostitution, especially in the cramped and boisterous neighbourhoods of Southwark and the Northern Liberties where members of the lower sort converged and shared the same public spaces as prostitutes.³⁵⁵ Prostitutes were accepted members of the community, and had been since the mid-eighteenth century, moving ‘freely and openly’ through the streets, parks, theatres and taverns, and were ‘familiar figures in the landscape of the disorderly city’.³⁵⁶ Although brothels sporadically came under attack, it was only when a complaint had been made about rowdy behaviour which disrupted the neighbourhood. This is a point easy to overlook when we currently live in societies that exclude prostitution socially, and in which sex-work is fuelled by exclusionary measures whether the act of prostitution is legal or not. Yet, even today the ‘co-existence of sex-work and residential living is by no means impossible’.³⁵⁷ It has been shown that prostitutes often stress the importance of being tolerated as part of the general community and its network of schools and shops, in addition to having friends living locally.³⁵⁸ Two centuries ago, red-light zones rarely existed, and prostitutes were more likely to belong to larger communities. In the ‘Whoars March’ incident, prostitutes were in effect protecting their own ideas or sense of community and belonging. Without wishing to deny that prostitutes were stigmatized by their profession, many prostitutes did seem to share the same rights and privileges as their fellow citizens. As Lyons notes, elite evangelical reformers whose interests lay in attempting to police prostitution, held convictions that were not widely shared in society at large.³⁵⁹ In short, prostitutes and prostitution were part and parcel of urban life.

The best indicator of larger social acceptance can be found in the vagrancy dockets, which testify to the overlap between prostitutes and non-prostitutes who lived and socialized in close proximity to one another. These were in liaisons that were sometimes sexual, but mostly involved activities that involved heavy alcohol consumption. Streetwalkers were arrested in their own groups but also in larger gangs

City of Eros; Stansell, *City of Women*, 173. Also see Carlisle, ‘Disorderly Women’ and Lyons, *Sex among the Rabble*.

³⁵⁵ Philadelphia’s brothel directory testifies to the fact that brothels were established in both working class areas and also more respectable neighbourhoods.

³⁵⁶ Carlisle, ‘Disorderly Women’, 549

³⁵⁷ Teela Sanders, *Prostitution: Sex Work, Policy and Politics* (London: Sage, 2009), 38.

³⁵⁸ Ibid.

³⁵⁹ Lyons, *Sex among the Rabble*, 345.

of men and women and they were charged by the city watch as vagrants or for drunk and disorderly behaviour. Prostitutes were often arrested alongside other members of the community who were not actually prostitutes, usually for street disturbances. This is most evident in the Vagrancy Dockets when groups of women who were clearly prostitutes were arrested alongside other non-prostitutes members for anti-social street behaviour.³⁶⁰ Women who engaged in prostitution mixed in the streets with other members of the lower sorts who no doubt worked in a variety of occupations. Shopkeepers depended on their custom, as did the many other businesses and commercial enterprises located in the area. And local drinking establishments that catered to the illicit sex trade depended on the presence of prostitutes to attract their own custom. The fact that Philadelphia swarmed with prostitutes illustrates that men and women of all classes accepted prostitutes. For the many who were arrested as many beyond the scope of the authorities probably lived relatively hassle-free. Importantly, despite the nature of their work, prostitutes often came from similar social backgrounds to their neighbours.³⁶¹ The records also demonstrate that white women of the lower sorts frequently mixed with those from different ethnic backgrounds. By the turn of the century, the burgeoning free black population of Philadelphia would feel the brunt of growing hostility from white middling and lower sorts. Racial tensions in the city were often expressed through poor relief policies, which essentially attacked the moral and sexual behaviour of African Americans.³⁶² Evidence of underlying animosity towards the black Philadelphian community was channelled by city leaders through aggressive policies condemning cross-racial sexual relations, which is clearly revealed in the vagrancy records. Yet prostitutes were slow to adopt such attitudes, and they were accordingly punished. When white prostitute Margaret Simmons was caught ‘in bed with a black man’ she was sentenced to thirty days hard labour in the workhouse as punishment.³⁶³ We often catch glimpses of Mary Carlisle and her friends mixing with blacks on the streets and alleyways of

³⁶⁰ For one example of many see 30 Aug. 1805, Vagrancy.

³⁶¹ While the details are sometimes sketchy concerning social backgrounds, the 1860s Prostitutes Register records parental occupations. Most of the native-Philadelphian prostitutes were the children of men and women who engaged in a range of occupations similar to those discussed below in a reconstruction of one neighbourhood in Southwark. Prostitutes Register, c. 1860-63.

³⁶² As Lyons notes, the Guardians of the Poor after 1810 began to ferret out black women from the almshouse who bore bastard children, and they became more of a target than their white counterparts. *Sex among the Rabble*, 361.

³⁶³ Margaret Simmons, 29 Aug. 1791, Vagrancy.

Southwark.³⁶⁴ When residents came under the eye of the city watch, they were often hauled into the workhouse in large groups of mixed gender and race. Diseased women did not only mix with members of their own race or ethnicity; they belonged to an increasingly multi-ethnic urban community.

3.5 Lydia and Sarah's Southwark Community and Neighbourhood

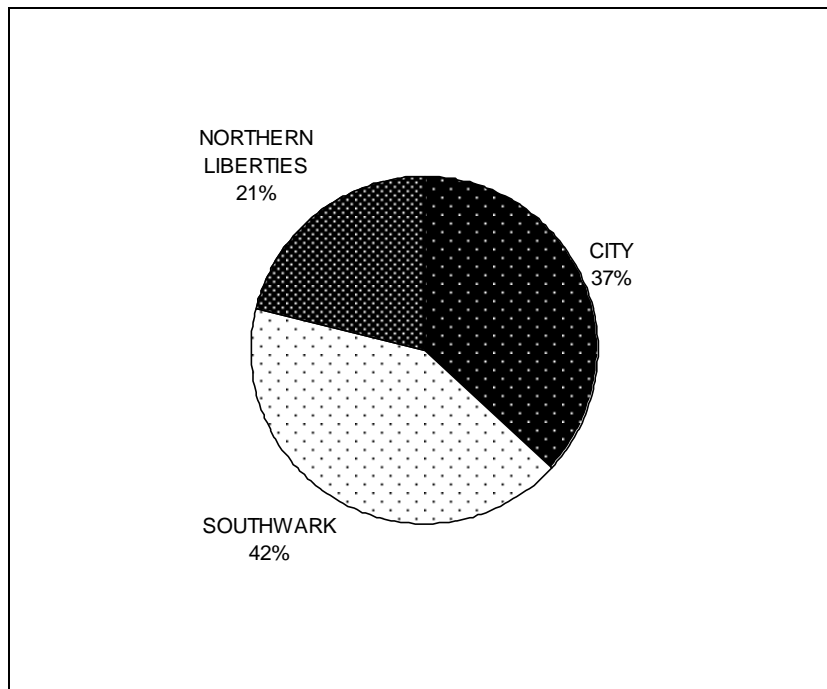
Graph 2 illustrates that a disproportionate number of diseased almshouse women also appeared in the Vagrancy Dockets, and were from Philadelphia's fringe district of Southwark.³⁶⁵ As noted, Southwark housed its fair share of brothels, yet the remaining areas of City (Philadelphia proper) and Northern Liberties were more densely populated.³⁶⁶ Southwark was adjacent to the River Delaware and the area's docks and wharves were home to sailors, labourers and itinerants. Along with their female companions, such inhabitants sometimes created a riotous environment, day and night. According to Alexander the 'whole area below South Street seemed dangerous because, as contemporaries commented, it was infested with sailor taverns [thus] a resort for all loose and idle characters of the city'.³⁶⁷ Poverty loomed very large here. Yet, those who participated in the area's underworld of sex commerce or criminality led lives that overlapped and intersected with those who followed more respectable livelihoods.

³⁶⁴ For an example see Feb. 1796, Vagrancy.

³⁶⁵ Graph 2 includes all women in the vagrancy dockets that have been cross-referenced with various almshouse records to discern residencies. While it is not always clear if a woman acted as a prostitute, the stock-phrase categories used by administrators certainly point toward this, given that women could only be arrested under the vagrancy law, and not for prostitution per se. Thus, the categories I used as indicators are: 'common prostitutes...keeping disorderly houses of ill fame...night walker...taken in a bawdy house...woman of disorderly character...idle prostitute...woman of ill fame...lewd vagrant taken at midnight...lewd stroller...soliciting the streets'. The three major districts that came under poor relief residency requirements were City (Philadelphia proper) and the outlying suburban areas of Northern Liberties and Southwark. The townships of Moyamensing and Passyunk broke away from the greater Philadelphia system in 1782.

³⁶⁶ In 1790 Philadelphia's population stood at 28,000 (64.7%), Northern Liberties at 9,913 (22.5 %) and Southwark, 5,661 (12.8 %). A count of almshouse residents shows that in proportion to population more inmates came from Southwark. According to Newman, 'Southwark accounted for 13 percent of the areas population in 1790, and less than 16 percent in 1800, yet it provided the almshouse with more than a fifth of its residents'. Newman, *Embodied Lives*, 153, footnote 40.

³⁶⁷ Alexander, *Render them Submissive*, 20. Interestingly, the areas north of the city housed more of the city's poor, and posed as much, if not more danger than Southwark.



Graph 2: Neighbourhoods of Diseased Almshouse Women Also Arrested under Vagrancy Law, 1789-1820.

Source: Vagrancy Dockets, 1789-1820, Daily Occurrence Dockets, Female Receiving Register (City n= 57, Southwark n= 65, Northern Liberties n=33)

Brothel-keeper Lydia Oakman and prostitute Sarah Thompson resided and worked in the Plumb Street neighbourhood of Southwark, home to a large proportion of Philadelphia's labouring people. Household economies in Southwark were often determined by the seasonal rhythms of the maritime and constructions trades and thus many poorer residents faced constant insecurity. Southwark women suffered as a result of their husbands' seasonal employment, and in an effort to support their families they were often compelled to take the most menial jobs available, in order to supplement already meagre resources. Although for a small number of residents there were opportunities for economic success, for the most part Plumb Street's population lived a hand-to-mouth existence.³⁶⁸ In Lydia and Sarah's neighbourhood, vagrants and itinerants also filled every available nook and cranny of the alleyways, and city directories enable us to place both women within the larger context of neighbourhood life. Sarah was just one of many almshouse women who inhabited and operated as a prostitute in this area of Southwark. Plumb Street housed several other brothel households as well as boarding houses that may also have been used as houses of

³⁶⁸ This neighbourhood's labouring population typifies many others situated in the City and Northern Liberties districts, especially north of Arch Street. For a description of the material realities of working-class districts of Southwark and the Northern liberties sections of the city see Smith, *Lower Sort*, 15-23.

assignment. Plumb Street was a small dark street, sandwiched between Shippen and German Streets. Later in the mid-nineteenth century, a journalist would remark upon it being the ‘centre of the most concentrated region of white prostitution in the city’.³⁶⁹

Just like their neighbours, prostitutes contributed towards creating and maintaining this community: economically, culturally and socially. Plumb Street’s prostitutes traded alongside men and women engaged in a variety of occupations. Most, although not all, of the street’s residents were low paid workers. Lydia and Sarah’s fellow labouring neighbours included labourers, rope-makers, sailors, weavers, shopkeepers, grocers, tavern-keepers, wet-nurses, schoolmistresses, barmaids, laundresses and even constables. Many of the working women of Plumb Street would have been single, whether widows, spinsters or deserted. Although many female occupations were not considered appropriate for women by respectable society, they nevertheless typified the work of lower sort women outside the home. The city directory and trade directories allow us to put a human face on this neighbourhood. Next to Lydia’s brothel lived Thomas Quail, a mariner. Close by lived George Paxton a brewer, George Wallheimer and his wife who kept a tavern, George Stockdale a grocer and John Shields a labourer. Lydia’s neighbours engaged in a variety of jobs, making for a mixed and vibrant working class neighbourhood. Jean Work, a widow and seamstress, also lived close to Lydia’s brothel. She resided on the same block as Eleanor Thompson and Margaret Wilson who were also widows. Margaret Wilson’s next-door neighbour may have counted Lydia Oakman and Sarah Thompson as customers for Jane Hemphill who was a midwife. It would certainly have been in Lydia and Sarah’s best interests to make connections with Hemphill or someone like her. Women such as Lydia and Sarah provided Jane with part of her income. Midwives, along with bleeders and a variety of other irregular medical practitioners lived and worked in the alleys and streets of the working class neighbourhoods of early Philadelphia. Hemphill was just one of several midwives who lived in the area, and she might well have served an important resource for prostitutes who became infected with sexual disease, fell pregnant or who needed medical help for sexual or general health problems. Although we will never know if the two women did use the services

³⁶⁹ Carlisle, ‘Disorderly Women’, 555.

of Hemphill, it is very likely that they visited her or one of the other midwives who lived and practised here.³⁷⁰

Lydia and Sarah inhabited these various economic, cultural and social networks prior to their almshouse admissions, whether simply talking with neighbours, procuring goods and services and even soliciting and serving their own custom. They no doubt also sought companions in the neighbourhood, and Lydia and Sarah more than likely shared with their neighbours the normal daily practices and routines of a community living close to the margins. Both women were far advanced in disease, and on occasion both were poor enough to need almshouse aid as a short-term measure unless they chose it above other options. Previous to their almshouse experience they had probably drawn upon various neighbourhood networks and support. To this end, they may well have been very much a part of the community. Most of the women who first made their way to the almshouse for venereal treatment would have learned from the advice and experience of their neighbours. Philadelphia was made up of face-to-face communities, which made for a prominent network of information providers, whether medical workers, fellow prostitutes, friends or simply neighbours. Wulf describes the intimate nature of Philadelphia,

Multiple networks of association existed among neighbours, reinforcing geographical community. Neighbours relied on each other for a variety of services and kindness, and could be brought together in times of crisis...Daily interaction -the walking and talking that scholars have emphasised as characterising the early city- gave shape to a geographically based, neighbourhood community.³⁷¹

To some of their neighbours who experienced either temporary or permanent poverty, Lydia Oakman and Sarah Thompson's choice to engage in prostitution may have been one that was understandable. Prostitution often provided the means to exist during temporary or more permanent poverty. That so many of city's lower sorts barely survived working at the most menial jobs suggests that they may simply have viewed

³⁷⁰ The geography of Plumb Street is reconstructed from James Robinson, *Philadelphia Directory for 1805, Containing the Names, Trades and Residences for this Inhabitants of the City, Southwark, Northern Liberties and Kensington* (Philadelphia, 1805). Also see the years 1810 and 1811. Given that the directories span two time-periods, and also that Sarah and Lydia used the almshouse at different times, much of this reconstruction has to be hypothetical, although the noted men and women did exist.

³⁷¹ Although Wulf illustrates these networks of exchange with the example of Philadelphia's militias during the Revolution, emerging as a result of neighbourhood associations, the same premise can be used to illustrate how diseased women accessed information on health matters. Wulf, *Not All Wives*, 122.

prostitutes as similarly struggling to make ends meet. Further, as Hill points out of New York prostitution, ‘many young girls...eased into streetwalking as an extension of their peddling and huckstering activities’. Moreover, as outlined, the Revolution unleashed new ideas of gender identity, particularly elite and middling women’s place as expressed through the politicized notion of Republican Motherhood. However, working class women rarely achieved, or even aspired towards, this middle-class ideal.

On the one hand, many local women were jealous of, and resented the presence of women like Lydia and Sara who served as a reminder that their husbands and sons spent their hard earned and badly needed family incomes on prostitutes. Yet, prostitution was first and foremost an occupation, albeit sometimes an occasional one and other working-class women may have identified with prostitutes -however loosely- through their shared gender and common economic struggles attempting to survive in Philadelphia’s wage-based economy. To this end, prostitution may have been viewed as a way to get by, especially by those women who engaged in the trade on a very casual basis. In areas such as Plumb Street where poverty was most apparent, poor women may have found it easier to identify with those who engaged in prostitution as a means to an end. Lyons has shown that some women who left their husbands managed to use ‘networks of independent women who resided in the bawdyhouses of the city when they left their homes to establish new lives’.³⁷² This strategy may have been most common amongst women whose husbands were temporarily at sea. Thus, while Lydia Oakman and Sarah Thompson may have been deemed offensive to polite society, they were accepted to an extent as part of the larger community of economically autonomous women. For Hill, many working-class women plainly viewed prostitution as ‘another aspect of the street-world’s exchange and barter of whatever commodity one had or could find’.³⁷³

As noted, in early national Philadelphia sexual behaviour remained moderately unchecked, unless of course it spilled into the realm of public poor relief.³⁷⁴ More forcefully put, working people’s ideas of what did or did not constitute deviancy

³⁷² Lyons, *Sex among the Rabble*, 286.

³⁷³ Hill, *Sisters Keepers*, 209.

³⁷⁴ For details on the frequency of illegitimate births and Philadelphia’s laws concerning bastardy see, Jack D. Marietta and Gail Rowe, *Troubled Experiment: Crime and Justice in Pennsylvania, 1682-1800* (Philadelphia: University of Pennsylvania Press, 2006), 204.

reflected those of local constables and law enforcers. Lyons contends that ‘the low numbers of arrests suggests that most women engaged in streetwalking were left undisturbed by the authorities’.³⁷⁵ In the cramped neighbourhoods of Southwark and the Northern Liberties, prostitutes were a visible presence and many prostitutes would have lived quietly and relatively free of interference from other ‘ordinary’ citizens.³⁷⁶ Although a large transient population passed through the areas surrounding Plumb Street, this disorderly environment was also community-based. In fact, despite the transient nature of Southwark, analysis of diseased women and their residencies tentatively suggests that those from this area enjoyed relatively strong community-based lives, perhaps to a greater extent than prostitutes from other parts of the city. Evidence from the almshouse records indicates that many women were probably established members of the community, and it appears many almshouse women had lived in the city either all their lives, or had at least resided there for a good many years. Twenty-year old divorced Lydia Ross had lived in Southwark for ten years when she first arrived at the almshouse for medical treatment for the venereal disease she had ‘caught at Sarah Coopers bawdy house in German Street’, also in Southwark. During her time in Philadelphia, Lydia likely cultivated a network of friends and workmates who resided close by. This was Lydia’s only spell of almshouse aid and given that ‘she has venereal disease badly’ and it would be a safe assumption that she had previously used neighbourly networks to access health care before her condition worsened and made almshouse treatment necessary.³⁷⁷

Although Lydia Oakman and Sarah Thompson found themselves in the almshouse on account of their diseased condition, prior to incarceration they would have found ready custom in their Plumb Street neighbourhood, which was part of a community noted for its many brothels. Certain taverns and tippling houses scattered throughout the city welcomed such women. Philadelphia’s prostitute population were therefore connected to the community within which they resided and worked, rather than living outside it. Their dwellings and work locations were scattered amongst the homes of a wide variety of lower sort trade’s-people, most of who left prostitutes alone to make

³⁷⁵ Lyons, *Sex among the Rabble*, 340.

³⁷⁶ As noted at the start of this chapter, prostitutes who show up in records for vagrancy or almshouse admission will not constitute a representative figure of the total prostitute population: most women who dabbled in prostitution or indeed made careers out of it would never come under the spotlight of the authorities.

³⁷⁷ Lydia Ross, 20 May, 1812, Dockets.

their ways in life. Diseased women, prostitutes or indeed any woman who engaged in the sale of sexual services were therefore part and parcel of a dense working class environment. Women like Lydia and Sarah were often legitimated by, and incorporated into the way of life very familiar to the working class tenement communities of mid to late nineteenth century New York City, as portrayed by Christine Stansell.³⁷⁸ That is not to say women were not castigated for their profession by those Philadelphia citizens who found their way of life offensive, yet a reading of the sources does pertain to some integration, which we are not accustomed to as members of societies that marginalize prostitutes into designated red-light areas.

3.6 Networks of Friends and Going it Alone

Like all other groups of women, common prostitutes relied on friendships and networks of support. Solace and companionship found in friendships would have helped to confront the hazards associated with prostitution, and integration within a specific network of prostitutes, or even with one fellow prostitute, provided information on the tricks of the trade and strategies for survival. Prostitutes were dependent on friendships, whether as close relationships built on genuine affection or as mere companions to stroll the streets in search of custom. Such companionship would also have prepared women with guidance on how best to deal with the public authorities, such as the almshouse steward John Cummings. Furthermore, Hill has shown through rare sources of personal correspondence amongst prostitutes that they enjoyed personal bonds with women who did not engage in prostitution. Often, these ties led non-prostitutes into the trade. Sociologist Eleanor Miller has suggested that often ‘the intersection of domestic and deviant street networks frequently provides a direct path to life on the streets’.³⁷⁹

Hill has also shown that despite their profession, nineteenth century New York prostitutes also kept family ties intact. The census and House of Refuge records allude to the existence of women who practised prostitution in the same brothel households as their sisters and cousins.³⁸⁰ The same is apparent in the Philadelphia almshouse, although the extent of this is not always clear unless two women’s surnames were so

³⁷⁸ Stansell, *City of Women*, ch. 9.

³⁷⁹ Hill, *Sisters Keepers*, ch. 9; Eleanor Miller, *Street Women* (Temple University Press: Philadelphia, 1986), 89.

³⁸⁰ *Ibid.*, 309.

unusual as to make a familial relationship likely. For instance, it is highly probable that twenty-one-year-old Mary Weed and twenty-three-year-old Sarah Weed were relations, either sisters or cousins. Mary sought admission to the almshouse in November 1807 and Sarah followed a month later. Both were treated for syphilis, and they eloped together in February 1808 after racking up substantial alcohol and medicine bills.³⁸¹ These domestic networks were not usually familial, and some may have overlapped within servant-based households. As shown, the almshouse often received servants who had caught venereal infection whilst in service. Susan Klepp has suggested that a large majority of Philadelphians in the late eighteenth century had migrated to the city on their own, leaving most of their kin behind.³⁸² A significant servant class of single women was formed from this group, and without a network of kin, they looked to one another to establish networks of friendship to replace those they had left behind, especially vital while living in a city that could appear uncertain and unfriendly. According to Jutte, evidence from eighteenth century Paris indicates strong ties existing in servant-based households, which ‘could facilitate integration into the local community’.³⁸³ This was particularly the case in humbler households where servants would be less cut off from the local community than they would be in rich or larger households. When the night-time lure of the metropolitan city beckoned, many of those servants had already established a network of friends.

Evidence from the almshouse indicates that women remained loyal to others who practised in the trade, and sometimes they refused to disclose the identities of their fellow workers. This is highlighted during a brief and extraordinary period between 1811 and 1812, when almshouse officials required women to reveal where they had contracted disease. Eleanor Fury, who lived at Mrs. Dolye’s boarding house on ‘Fifth Street between Shippen and South’ in Southwark, was refused medical treatment and discharged ‘in consequence of her refusing to give evidence against a person with whom she lived, for keeping a house of ill fame’.³⁸⁴ Eleanor may even have been acquainted with Sarah Thompson, who arrived at the almshouse the same month from a brothel located near Doyle’s boarding house, which was in fact situated close to

³⁸¹ Philadelphia Almshouse, Weekly Return of Patients, 1807.

³⁸² Susan Klepp, *Philadelphia in Transition*, 87-93.

³⁸³ Robert Jutte, *Poverty and Deviance*, 93.

³⁸⁴ Eleanor Fury, 4 Dec. 1811. Dockets.

Plumb Street. Perhaps the best example of this unity, or sub culture of prostitutes can be found in the venereal ward 'Whoars March' episode. After one episode of frequent urban disorder in Southwark, the local high constable placed a notice in the *Pennsylvania Gazette* complaining of the 'several riots...lately committed in this district of Southwark owing to the great number of ill regulated taverns, tippling houses, &c...selling liquor on the Sabbath day to disorderly persons'. Coincidentally, an evangelical mission to suppress Southwark 'vice' emerged within months of the polishing room riot.³⁸⁵

The almshouse registers reveal glimpses of the women who were actually involved in venereal ward riot. It would seem that around twelve women were incarcerated in the venereal ward during the riot and these included the young blind woman Rachel Ward; Mary Reed, who was noted in the Vagrancy Dockets as a 'common disturber of the neighbourhood' and in the Daily Occurrence Dockets as a 'pockey trull'; Elizabeth Bradley, who was a 'common nuisance'; Margaret White, (also known as Peggy Farrell) who was a 'well known venereal customer...[and]...noted Lady of the Town'; the 'convict' Margaret Jackson and Anne Smith who had been 'sent in from a Southwark bawdy house'. Leah Martin was also involved and may have acted as ringleader, given that she was 'thrown out for breaking rules' a month later. Nine of the twelve women probably involved in the riot came from Southwark. Margaret White for instance, who used a host of aliases, was no stranger to trouble and was arrested under the vagrancy laws 'for her involvement in a riot' the following year. Prior to one almshouse admission, she was removed by the city watch from 'a disorderly house', most likely a brothel in a Southwark alley adjacent to South Street.³⁸⁶

Without wanting to overstate the feasible social cohesion, it is possible to locate a clear sense of community amongst the prostitutes who aided and abetted one another, especially in times of dire need. When diseased Rebecca Maglow was 'found lying under a shed by her friend', the latter immediately obtained an order of Recommendation and took Rebecca to the almshouse. Indeed, many prostitutes escorted their co-workers to the almshouse in times of need. When Eleanor Redman

³⁸⁵ *Federal Gazette and Philadelphia Evening Post*, 16 Oct. 1790.

³⁸⁶ Margaret White (Peggy Farrell), 11 June 1792, Vagrancy; Jan. 1790, Jan. 1791, Dec. 1792, Dockets,

was so ‘eaten up with venereal disease’ that she ‘was deprived by the use of her limbs’, Cummings noted that Ruth Gilbert, ‘another of her profession...escorted her to the almshouse’. Yet Ruth was too late, and her companion died the following day. Like Eleanor, Maria Carr drew upon a support network. In a ‘highly venereal state’, she was ‘brought to the almshouse [in] a carriage by two of her Equals’, as was Mary Adams who was ‘accompanied by the same sort of women in a coach...from a bawdy house’. When prostitutes were officially discharged, it was often at the instigation of a friend. Thus Grace Boon, ‘one of the Venereal Ladies...was taken out by a Sister of Equal Fame’.³⁸⁷

While we have seen that diseased almshouse women and prostitutes could form community-like bonds, an undercurrent of violence underpinned the lives of many of the city’s poorest women and prostitutes. In fact, some diseased almshouse women appeared in the vagrancy dockets as formidable characters. Many prostitutes led violent lives, and while they formed bonds with others in similar social and economic situations, they could just as quickly turn on one other. The bonds or close friendships formed between such women were complex. For instance, jealousy often prevailed, whether it was caused by rivalry in soliciting wealthier clients or simply in envy of another woman’s looks. Tension amongst prostitutes is evident in the records, which highlight women who were brought before the magistrates for assault and battery on each other. Mary Nance was one such streetwalker who was jailed for one month in 1791 ‘for beating Ann Drain’, another of her kind.³⁸⁸ Mary Wilson a Southwark resident and ‘notorious prostitute’ came to the attention of locals for fighting on several occasions, as did Elizabeth Williams who roamed the brothels of the city and was caught ‘fighting in a bawdy house after midnight’. Hostilities often broke out in brothels such as Sarah Wilson’s, whose ‘riotous ill famed house’ was familiar to those policing the area.³⁸⁹

Moreover, the evidence indicates that some of these women suffered from severe alcohol and drug abuse. While this chapter has sought to recover the voices of

³⁸⁷ Rebecca Maglow, 11 Jun. 1804, Eleanor Redman, 3 Dec. 1790, Maria Carr, 27 Dec. 1797, Mary Adams, 25 Nov. 1796, 2 Dec. 1791, Dockets.

³⁸⁸ Mary Nance, 22 Jun., 1791, Vagrancy. The Vagrancy Dockets illustrate many similar examples.

³⁸⁹ Mary Wilson, 29 July 1790, 25 July 1796, Elizabeth Williams, 25 July 1818, Vagrancy

diseased almshouse women, we cannot escape the fact that however assertive and self-assured many were, a good many of their number were alcoholics. Mary Lane was a habitual almshouse patient who used the infirmary for venereal treatment throughout the 1790s. Mary was clearly homeless for much of her life, and she moved between the Northern Liberties and Southwark, often attracting the notice of each district's local watch. Lane was also a single mother, and on most of her admissions she was described as an 'impudent drunk'. Mary clearly struggled with life, and despite her dependency on alcohol she kept her child by her side whenever she could. On one occasion she eloped over the almshouse fence along with her infant, John Lane. When her son died she absconded from the almshouse for the purposes of attending 'the burial of her child but did not return'. Drink often got the better of Mary. On one occasion she had been arrested for 'nearly killing her child' while she was 'intoxicated'. While it is easy to be unsympathetic towards Mary given that the steward presented her as a common drunk, she clearly strove to keep her child and suffered immensely after he died. For reasons unknown, she left Philadelphia just after the death of her child, yet four years later she was 'removed from the township of Cheltenham' and returned to Philadelphia in a state of derangement. From her first admission, she had in fact been noted as 'poor and unhappy'.³⁹⁰ Many of those women shared poverty and misery. While not all diseased women were drawn specifically from the lower sorts, once diseased, poverty loomed for many of them.³⁹¹ Yet being part of a culture of poverty did not guarantee ties with the community.

Amongst the women who were incarcerated in both the venereal almshouse ward and in the city workhouse, many did not enjoy supportive communities and they appear to have led lonely lives isolated from their nearest communities, and were often dependent on alcohol to soften the many blows life struck. Alcohol abuse existed as a very real social problem amongst lower class Philadelphians and none more so than the city's poorest women and those involved in sex commerce. Between 1794 and 1797 Elizabeth Ross a 'young dissolute prostitute' was incarcerated in Walnut Street Jail no less than five times, for being 'lewd and disorderly' and 'enticing a man'. She often roamed about the streets of the Northern Liberties with groups of locals

³⁹⁰ Her mental state was in all probability connected to alcohol abuse, venereal disease, and the loss of her young infant. Mary Lane, Nov. 1789, 15 Mar 1791, 27 April 1791, May 1791, John Lane, 26 June 1791, Dec. 1796, April 1798. Dockets, 23 Feb. 1791, 29 April 1791, 20 July 1807, Vagrancy.

³⁹¹ For a discussion on the historical concept of a 'culture of poverty' see Jutte, *Poverty and Deviance*.

characterised as ‘idle disorderly persons’. On one occasion she was caught ‘Misbehaving at John Sorten’s House’.³⁹² Elizabeth kept company with Sarah Wilson, who on one occasion was jailed after being found drunk, ‘Lying in the streets’. If we consider diseased women in the context of their capacity for agency, it is possible that some of their bravado was fuelled by alcohol.³⁹³ Yet, the flipside was that such women needed to feel a sense of belonging, and often we only have the accounts of violence, hatred and misery that appeared in court records and reports in the local papers. The everyday mundane or commonplace events in a prostitute’s life involving amiable and neighbourly contact were simply not worthy of public record.

However, while a strong sense of community can be traced amongst almshouse women, as Smith reminds us ‘we should resist idealizing the “community life”...led by the lower classes’.³⁹⁴ In any case, for as many women that were part of a community of prostitutes (or other diseased women associated with them), many led a lonely existence cut off from kin, neighbours and friends, despite living in bustling neighbourhoods. As Smith notes, ‘their neighbourhoods were in continuous flux as residents moved in and out in a perpetual cycle of subsistence migration’.³⁹⁵ Isolation, despite living in an urban area, characterised the lives of many lower class diseased women, and this would certainly have been the case for those living without family in the Northern Liberties and Southwark. Southwark in particular was home to a large migrant population and many transients were lacking networks of kin and friends.³⁹⁶ Women who lived solitary lives and suffered from a hideous disease would have found it impossible to retain some autonomy over their lives. Such was the case for Maria Yost who, after living for four years in Southwark, caught venereal disease after she had separated from her husband. She was ‘much infected’ so was ‘unable to find work’. Maria lived an alienated existence as a ‘friendless woman’ also without family to aid her while she was sick, thus leaving her in an extremely vulnerable

³⁹² Elizabeth Ross, 2 Jul. 1794, 1 Aug. 1796. 20 Jun. 1797, Vagrancy.

³⁹³ During a Committee meeting later in the nineteenth century, one manager complained that ‘of the women’s syphilitic wards, containing 40 patients, only 10 are believed to be temperate’ and ‘of the remainder it may be said that lewdness and intemperance have brought them to the house’.

Philadelphia Almshouse, Committee of Managers Meeting, May, 1864.

³⁹⁴ Smith, *Lower Sort*, 200.

³⁹⁵ Ibid.

³⁹⁶ Susan Klepp, ‘The Working Poor in Philadelphia: Gender and Infant Mortality’, in Smith, *Down and Out*, 74.

position.³⁹⁷ The records also reveal that many women lacked childcare assistance and often arrived for medical help with their child in tow. Mary Bowley applied for admission in 1797 ‘with a cancer in the nose...the effects of venereal disease’. She claimed her ‘husband gave her the disease twelve months ago since which time he has never been near her’. Mary was ‘poor and destitute of friends’. Evidently Mary was also devoid of familial resources to the extent that she was unable to care for her child, Charlotte, who it was noted had been in the almshouse for the previous year, ever since Mary’s husband absconded. There are several examples similar to Mary’s, and single mothers simply had little option but to turn to the almshouse in times of need.³⁹⁸

Some women passed on disease to their children. Perhaps even more than poor Philadelphia women, prostitutes and diseased almshouse women buried their children in staggering numbers. Rebecca Robeson was admitted in 1793 along with her one-year old son Martin Robeson, who ‘caught venereal disease from his mother’s breast’. This child died not long after arrival, and two months later, his mother was ‘permitted to go’.³⁹⁹ The sheer numbers of women who abandoned their newborn babies illustrates just how difficult life could be for Philadelphia’s mothers who lived on the economic margins without networks of kin and friends. Children were left at the doors of neighbours, at the almshouse, or simply left to fend for themselves on the streets and alleys of the city. One woman ‘abandoned her baby nearly to perish’ and was committed for thirty days to the workhouse. John Cummings was often perturbed by the numbers of newborns abandoned at the almshouse by their ‘unnatural mothers’.⁴⁰⁰ Some women were simply too intoxicated to look after their children, like Mary

³⁹⁷ Maria Yost, 17 July, 1800, Dockets.

³⁹⁸ Mary Bowley, 13 Aug. 1801, Dockets. That so many women eloped with their children also indicates the fence posed little in the way of obstruction.

³⁹⁹ Martin and Rebecca Robeson, Jan., Mar., 1793, Dockets.

⁴⁰⁰ Mary Carr, 30 Oct. 1796. Vagrancy, Mary Carr, John Cummings, June, Dec. 1797, Dockets. Infanticide constituted a real problem in early Philadelphia, but the severity of the laws concerning prosecution were lessening by the end of the eighteenth century, (execution was often a woman’s fate in the seventeenth century) and women who concealed the deaths of their new born infants were increasingly not being brought to trial. According to Rowe, leniency, compassion and often ‘any excuse enabled acquittal’. After the Revolution, the public lost interest in punishing female involvement in crime, with more concentrated efforts against male crime. Sexual behaviour, unless perceived an economic burden was prosecuted less aggressively than it was pre-war. G.S. Rowe, ‘Women’s Crime and Criminal Administration in Pennsylvania, 1763-1790’, *Pennsylvania Magazine of History and Biography*, Vol. 109, No. 3 (1985), 367. Also see, Sharon Burnston, ‘Babies in the Well: an Insight into Deviant Behaviour in Eighteenth Century Philadelphia’ in, *Pennsylvania Magazine of History and Biography*, Vol. 106, No. 2 (1986), 171.

Dickenson and Charlotte Bennett who were arrested for being ‘lewd prostitutes’ and ‘an evil example to their children’. Like their mothers, poor children were susceptible to a range of diseases associated with their class and the health of their mothers. According to Klepp, ‘poor infants faced a larger number of disease and environmental risk factors during their first year of life than did their wealthier counterparts’.⁴⁰¹ Children born to diseased women suffered the additional health risk of venereal infection and its associated complaints. The young bodies of those infants who contracted infection from their mothers stood very little chance of survival.

3.7 ‘Whoars March’: customs and strategies

Diseased women therefore often managed to carve out a community, and responded to their condition and the almshouse authorities by using a variety of strategies in order to negotiate the terms of their almshouse stay. Often these strategies emerge as being very conservative in nature, despite the fact they acted in rebellion against the nature of almshouse confinement. Diseased prostitutes were often attempting to cling to customary traditions more representative of an earlier time before heavier urbanisation. The actions of the women involved in the ‘Whoars March’ tells us a great deal about how they understood their place in society as well as the almshouse. Reading between the lines of the incident reveals that these diseased women held a firm belief in what they perceived as rightfully theirs. They imposed, or at least attempted to enforce -and often managed to sustain- their own rules. At base, these women acted as both individuals and as a collective in order to secure free health care. Yet their claim was also reinforced by a conviction that this care would be dispensed within an assumed order. The steward’s claim that ‘those insolent hardened Husseys go on dispensing all Rule & Order’ resonates not only for its suggestion that diseased women retained a degree of power inside the almshouse walls. Cummings was also alluding towards the existence of a firm belief in customary rights and procedures. While these women did not exactly accept the ideal of “deference”, they nevertheless expected and understood their position and identity in society. These shared behaviours and concepts fit with the classic model proposed by E.P. Thompson,

⁴⁰¹ Klepp, ‘Infant Mortality’, 74.

the conservative culture of the plebs as often as not resists, in the name of custom...innovations ...which rulers, dealers or employers seek to impose...Hence the plebeian culture is rebellious...but in defence of custom.⁴⁰²

This breaks down when relationships are complicated by change, which is illustrated by the Whoare's March. Jane Bickerdite, the nurse and ex venereal patient who was the target of rebellion, was attacked by prostitutes when she transgressed her given role as inmate. The consequence for Bickerdite was public humiliation in the form of the early modern European custom of charivari (rough music). Although Philadelphia was experiencing the onset of industrialisation with rapid urbanisation, its communities nevertheless retained some traditional customs associated with pre-modern communal behaviours. Such popular rituals were still an important strategy available to ordinary people during this period, employed to enforce cultural, economic and social norms.⁴⁰³ For these diseased pauper women, this ritual was used as a way to legitimise their own customary place and right in society. Bickerdite was perceived as a corrupting influence who threatened the status quo. Moreover, as Barry Reay suggests, charivari could 'only be effective when the target is sufficiently integrated into the community'.⁴⁰⁴ Until Bickerdite became nurse of the ward she was perceived to be one of them, an almshouse patient. Yet the nurse had overstepped her mark by collaborating with the almshouse authorities. This illustrates how pre-existing values amongst diseased women were to an extent constrained by their own conventions. We will never know the reasons behind the occurrence of the 'Whoars March'. Diseased women stigmatised Bickerdite with her new-found autonomy in the almshouse, which she had perhaps exercised to an extent deemed unnecessary by the venereal ward patients. Perhaps she had upset one individual, rather than the group as a whole. In any case, as Jutte observes, stigma derives 'not so much from the occupation of...social roles as from the way in which such roles are expressed through an individual's performances'.⁴⁰⁵ Moreover, these modes of stigmatization can be channelled through various mediums such as signs, gestures or language. In this instance, the age-old customs of ritual and riot were the vehicles of resistance.

⁴⁰² Edward Palmer Thompson, *Customs in Common* (London: Merlin Press, 1991), 9. Also see Henry French and Jonathan Barry, *Identity and Agency in England, 1500-1800* (Basingstoke: Palgrave Macmillan, 2004), 5.

⁴⁰³ This is particularly evident during the Revolution when common folk engaged in public rituals such as parading and tarring and feathering in response to change.

⁴⁰⁴ Barry Reay, *Popular Cultures in England, 1550-1750* (London: Longman, 1998). 160.

⁴⁰⁵ Jutte, *Poverty and Deviance*, 158.

Both the almshouse and vagrancy records reveal the existence of a subculture of prostitutes, distinct from but often related to other groups of lower class women. Although these women acted alongside others engaged in different professions, they were also part of a separate group of prostitutes. Peter King has shown how social inequalities had positive effects amongst a group of eighteenth century England's urban poor that in fact helped them to shape their identity as a group. King found this sense of social identity amongst poor Buckinghamshire labouring men, and he suggests that it was crucial for bestowing agency, 'to play off the petty sessions magistrates against the parish officers...and to exploit minor differences between the two latter groups'.⁴⁰⁶ This is echoed by the diseased Philadelphia women's manipulations of the managers and John Cummings. Managers and overseers quibbled over the aims and nature of the almshouse; managers and physicians engaged in a constant struggle over the care of inmates, and the steward became tangled within this web. This left room for manipulation of the situation by inmates. Moreover, like King's poor labourers, diseased women also drew upon and often clung to, customary ideas concerning their right to relief. Women who were part of a community of prostitutes inscribed themselves with a social identity, which gave them courage to draw upon medical relief available at the almshouse. Thus, while the almshouse managers strove to enforce regulations over inmates, diseased women were simultaneously setting their own precedents.

⁴⁰⁶ Peter King, 'Inequality, Identity and the Labouring Poor in Eighteenth Century England', in, French and Barry (eds.), *Identity and Agency in England*, 83.

PART TWO

Chapter 4

Setting the Scene:

The Perils of Philadelphia's Medical Marketplace

‘What did people do when they got sick...a couple of centuries ago’ asks Dorothy and Roy Porter.⁴⁰⁷ Disease and illness permeated late eighteenth and early nineteenth century Philadelphia. Historians have long believed that during this period the household was *the* primary arena for healthcare. This chapter will explore how people obtained their medicine, and identify where the sick Philadelphian sought therapy from a medical practitioner. More precisely, we will travel through Philadelphia’s medical marketplace alongside those women suffering from venereal infection to ascertain how she responded to disease, either before, or as an alternative, to almshouse care. We will see that the plebeian underbelly of Philadelphia was serviced by a range of health care providers. As outlined, many diseased almshouse women hailed from the city’s outskirts, especially its southern district of Southwark, which was guarded by a vast army of medical practitioners.

Prostitutes were vulnerable to infection almost instantaneously upon commencing life as a prostitute. Of those women recorded in a mid-nineteenth century almshouse Prostitutes’ Register, fifty-one percent became diseased within the first year.⁴⁰⁸ When a woman first realised she was diseased she had two fundamental options. On the one hand she could ignore the infection and carry on with her daily business. Some diseased women were little affected, but others who continued working as prostitutes aggravated their condition, and were re-infected by new customers. On the other hand she could choose to deal with it immediately and there were various ways this was possible. First, if she was poor or simply distrustful of unorthodox healers, she could go to one of Philadelphia’s dispensaries for the poor, or indeed the almshouse. If she was very sick, the Overseers of the Poor may have decided that she required a visit from an outdoor physician. Second, she could treat the site of infection herself by purchasing one of the many patent “cures” available from apothecaries, healers and

⁴⁰⁷ Dorothy and Roy Porter, *Patient’s Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge: Polity Press, 1989), 3.

⁴⁰⁸ This data is extracted from a source generated by almshouse officials in the early 1860s. It is impossible to calculate such information for the earlier period. Guardians of the Poor, Philadelphia Almshouse Prostitutes Register, c. 1860-1863, PCA

booksellers. Third, she may have paid any one of the city's many healers to medicate her.

This chapter will argue that mercury was widely commercially available to diseased women in cheap preparations, often in large doses. It will highlight that Philadelphians were particularly fond of using botanical compounds as medicinal ingredients. This crossed the social strata; from the back-alley midwife to the domestic goddess to the eminent hospital physician. Importantly, this penchant for botany reached into the almshouse, as chapters five and six will illustrate.

Unless she lived the most precarious existence and was also dependent on food and shelter, a diseased woman made her way to the almshouse infirmary based on her understanding of the nature of cures available. Despite being confronted with a wide range of medical options in an open market, her decision to go the almshouse was influenced by the damaged bodies she saw around her, belonging to those women who had chosen those options, yet were still dangerously ill. Most would have used commercially available remedies, the majority of which contained some degree of mercury. Yet a growing number of Philadelphians were beginning to question a treatment that appeared more dangerous than the disease itself. Thus women often selected almshouse medicine based on a rational choice. Over the next chapters we will see that almshouse treatment often involved liberal amounts of alcohol and opium to numb the effects, and a more limited administration of mercury (if any) than might have been experienced at home or in the Pennsylvania Hospital.

4.1 Institutional Medicine

The most striking aspect about sickness in early national Philadelphia was the existence of multi-level healthcare networks, from private and public institutional care, to a wide range of services provided throughout the city.⁴⁰⁹ Sick Philadelphians were

⁴⁰⁹ There was also the Friends' Almshouse run by the city's Quakers. Built in 1729, this poorhouse provided maintenance for those in need who belonged to the society, and provided for the purchase of medicines when an impoverished member became sick. *John Fanning Watson, Annals of Philadelphia and Pennsylvania: in the Old Time*, Vol. 1 (Whiting & Thomas: Philadelphia, 1856), 427. In addition, there was Christ Church Hospital, which Moreau de St. Mery described as a 'small two storey building' on the north side of Mulberry, which functioned as a charity medical provider. Kenneth Roberts and Anna M. Roberts (eds), *Moreau de St. Mery's American Journey, 1793-1798* (Garden City: New York, 1947), 356.

well placed if they became ill, and as archaeological historians have shown, medical care in Philadelphia was the best to be had throughout the colonies.⁴¹⁰ The eighteenth century was a pivotal time for the emergence of medical provision for the poor. Wealthier citizens preferred home treatment where medical attention could be provided by a personal physician, while for the labouring virtuous poor, the Pennsylvania Hospital offered medical care. There was also the Philadelphia Almshouse, functioning at once as refuge and medical provider for the city's indigents. Although there is disagreement about which hospital came first, the Pennsylvania Hospital was the earliest institution dedicated solely to relieving the sick poor population. This was founded upon the basis of charitable donations, much like the British voluntary hospitals that also relied on private benefaction.⁴¹¹ It also worked on the premise of a recommendation system, and beds were intended for the working "worthy" poor. Venereal patients in receipt of medical care in the Pennsylvania Hospital were singled out to pay extra fees, although not necessarily as an agent of moral punishment.⁴¹² The almshouse dispensed public charity not solely medicine, yet it nevertheless surpassed the Hospital as the principal medical provider for the city's sick population. Unlike the Hospital, the almshouse infirmary was not closed off to those deemed the 'unworthy poor'.

In order to deal with a rapidly growing population, from 1780 a system of medical outdoor relief was implemented by the almshouse managers, and doctors connected with the institution were required to 'attend and prescribe for those who, though not inmates...were dependent on its resources for professional aid'.⁴¹³ These physicians, according to ex almshouse doctor David Hayes Agnew, 'visited the sick poor in the secluded lanes and alleys of this metropolis'.⁴¹⁴ Women suffering from venereal

⁴¹⁰ John L. Cotter, Daniel G. Roberts, Michael Parrington, *Buried Past: An Archaeological History of Philadelphia* (Philadelphia: University of Pennsylvania Press, 1992), 46.

⁴¹¹ The Pennsylvania Hospital also admitted pay patients (as did the almshouse). According to Richard Shyrock, the Hospital was indeed superior to most others of its time, although he points out it did have its counterparts in 'some of the better European institutions'. Richard Shyrock, *Medicine and Society in America: 1660-1860* (New York: Cornell University Press, 1962), 23.

⁴¹² This practice was also common in Britain, and the reason for charging extra fees was in light of the expensive procedures carried out here, which will become clearer in chapter six. William H. Williams, *America's First Hospital: The Pennsylvania Hospital, 1751-1841* (Wayne: Haverford House, 1976), 76.

⁴¹³ David Hayes Agnew 'The Medical History of the Philadelphia Almshouse', in John Welsh Croskey, *History of Blockley: a History of the Philadelphia General Hospital from its Inception* (Philadelphia, 1929), 7.

⁴¹⁴ In 1800, twenty-four physicians visited the poor in their homes and furnished them with medical aid, covering eleven districts. *Ibid.*

infection qualified for outdoor relief, even those who were suspected prostitutes. Sarah Anderson was ‘a frequent in & outdoor customer’, making several trips to the almshouse venereal ward, yet she was also visited by a physician in her home on other occasions.⁴¹⁵

Unwell Philadelphians could also visit the Philadelphia Dispensary established in 1786 to receive the ‘indigent sick, of every description and every disease’. Dispensaries were established in America in the late eighteenth century to provide free medical attention and drugs. The sick poor were thereby furnished with medicine as outpatients, and these institutions later evolved into the outpatient departments we are now familiar with in modern hospitals.⁴¹⁶ Like the Pennsylvania Hospital, the ethos behind America’s dispensaries was to provide relief to the ‘worthy’ poor, and not, explains Charles Rosenberg, the ‘prostitute, the drunkard, the lunatic and the cripple’.⁴¹⁷ Instead, this latter group would come under the responsibility of the Overseers of the Poor.

The Dispensary’s regulations required those who visited to be ‘recommended by the Contributors’. Doctors visited the Dispensary three days a week and ‘prescribed ... at stated times’, usually for one hour. In 1808 there were in total ‘six attending and two consulting physicians’ attached to the institution, and an apothecary living on site, whose business was to ‘compound and deliver medicines’. If a patient was too ill ‘to go abroad on Dispensary days’, they were ‘visited at their respective places of abode’.⁴¹⁸ In 1816 the Dispensary established offshoot operations in the Northern Liberties and Southwark in an attempt to accommodate the city’s sprawling and densely packed fringe areas. The introduction of these institutions coincided with the reduction in outdoor poor relief provided to women by the Overseers from 1816.⁴¹⁹ Like the predecessor, the Northern and Southern Dispensaries theoretically catered for

⁴¹⁵ Sarah Anderson, 20 Sep. 1804, Mar. 1808, Dec. 1809, Dockets.

⁴¹⁶ Shyrock, *Medicine in Society*, 105.

⁴¹⁷ Rosenberg, Charles, E., ‘Social Class and Medical Care in Nineteenth Century America: The Rise and Fall of the Dispensary’, *Journal of the History of Medicine and Allied Sciences*, Vol. 63, No.4 (1974), 32-54, quote from 43.

⁴¹⁸ Rules of the Philadelphia Dispensary for the Relief of the Poor (Philadelphia, 1808); Account of the Philadelphia Dispensary (Philadelphia, 1802).

⁴¹⁹ Susan Klepp suggests this was in response to the growing numbers of poor women drawing on poor relief who were perceived by the public authorities as ‘insolent’ and ‘demanded relief as a right’, without being ‘properly thankful’. Susan Klepp, ‘The Working Poor in Philadelphia: Gender and Infant Mortality’, in Smith, *Down and Out*, 75.

the ‘worthy’ poor and not prostitutes. However, although admission lists do not survive for the most part during this period, a rare source pertaining to the Northern Dispensary indeed suggests that many diseased women made their way through the doors of this institution.⁴²⁰ Thus, one Boston physician could complain that the ‘most depraved and abandoned character frequently apply who think they have the right of choice between the almshouse and the infirmary’.⁴²¹ Rosenberg acknowledges that ‘the plight of those fallen in fortune...touched [dispensary] physicians deeply’, thus they may have displayed an unusual sympathy for those women who sought venereal treatment.⁴²² It is likely that prostitutes were often able to draw on the treatment provided by the dispensary if they produced a plausible story regarding disease transmission.

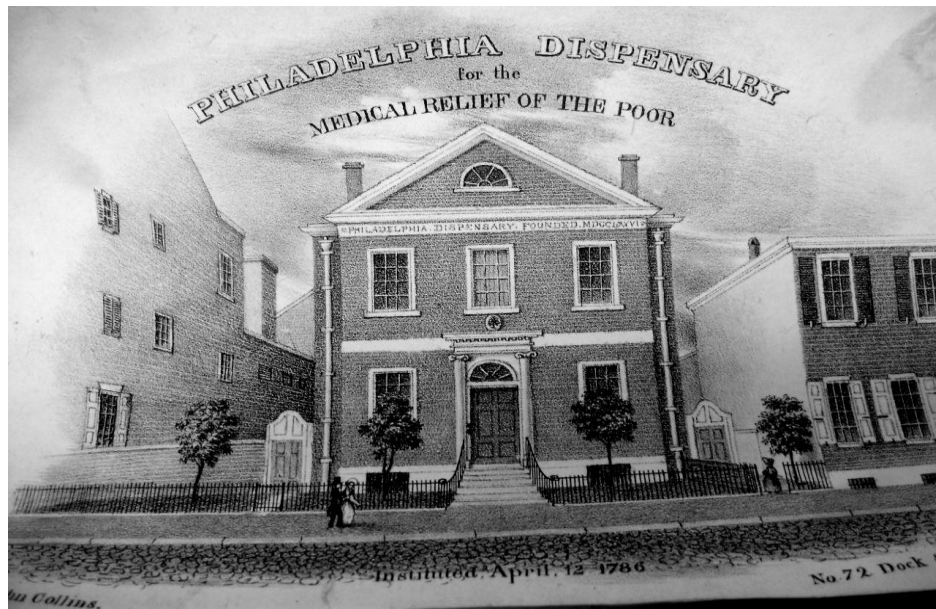


Figure 2: Philadelphia Dispensary for the Medical Relief of the Poor, 1786 Source: PHA.

⁴²⁰ As touched upon in chapter one, the records of the Northern Dispensary testify to syphilitic customers treated regularly until the 1820s after which time venereal cases disappear from the record altogether. Thus, by 1835 the lying-in department of the Northern Dispensary stated it could ‘only aid woman of a respectable character’. Also see Hilary Marland ‘Lay and Medical Conceptions of Medical Charity during the Nineteenth Century: The Case of the Huddersfield General Dispensary and Infirmary’, in Barry and Jones, *Medicine and Charity*, 157.

⁴²¹ Quote taken from, Rosenberg, ‘Social Class’, 43.

⁴²² Ibid 166-8.

The North American population tripled between the first half of the eighteenth century and 1800. Consequently, rapid urban growth in Philadelphia dictated that many of the city's sick poor would not benefit from either the Pennsylvania Hospital or the systems of medical relief implemented by the Overseers of the Poor. The capacity of both institutions simply could not be stretched to accommodate demand, and although there were a large team of doctors administering outdoor relief, the catchment area was simply too large to cater to demand. Thus, a wider medical marketplace was nurtured and a host of alternative providers flourished in the country's largest port city.

4.2 Philadelphia: the Crucible of Medicine

Mary Fissell has criticized historians for conceptualising early modern marketplaces within static and unchanging economic and social frameworks. She suggests much of the historiography has become absorbed by popular consumption, which for the most part gives scant regard to contexts of regulation or authority.⁴²³ While this chapter focuses on consumer behaviours, we should outline Philadelphia's place in the marketplace of commercial supplies. As a busy port, the city held important and considerable trade links with Britain, Continental Europe and the West Indies, not to mention coastal trading up and down the eastern seaboard.⁴²⁴ From the early eighteenth century, the Philadelphia's docks were an expanding hub of mercantile activity, and the city became the leading commercial and financial centre of late eighteenth and early nineteenth century North America. Over the course of the period, improved communications in terms of larger ships facilitated international trade, and internal developments of transport networks made for a speedier exchange of newspapers by wagon, steamboat and eventually, rail.⁴²⁵ In short, trade in all types of goods and raw materials expanded in Philadelphia through the course of the eighteenth century. By the early nineteenth century, the city was in the throes of a consumer revolution, and medical entrepreneurs were part of this process.⁴²⁶

⁴²³ Mary Fissell, 'The Marketplace of Print', in Mark S.R. Jenner and Patrick Wallis (eds.), *Medicine and the Market in England and its Colonies, c.1450-1850* (New York: Palgrave Macmillan), 109. For a discussion of the historiography of the concept of the "medical marketplace", see Jenner and Wallis's chapter 'The Medical Marketplace' in the same collection of essays.

⁴²⁴ Sheryllynne Haggerty, *The British-Atlantic Trading Community, 1760-1810: Men, Women and the Distribution of Goods* (Brill Academic Publishers: Philadelphia, 2006), 26.

⁴²⁵ *Ibid.*, 19-20, 23-6.

⁴²⁶ Millicent R. Lawell, 'Apothecary Shops of Colonial Times', *Journal of the American Pharmaceutical Association*, Vol. 25, No.3 (1936), 235.

Philadelphia's economic climate was well adapted to host a thriving marketplace of medicine, thus Susan Klepp has labelled the city 'an early medical centre and the American hub of an international pharmaceutical trade'.⁴²⁷ Although options for free professional treatment were somewhat limited for the poorer classes, medical authority was far from absolute and there were a host of alternatives. Lisa Rosner has shown that Philadelphia was 'unusual for its high concentration of doctors'.⁴²⁸ By the early national period, Philadelphia not only boasted structured medical provision, but also varied services and medical products, all encouraged by an open marketplace. Such a climate was able to prosper in the country's more egalitarian atmosphere than say Britain, or German Cameralism whereby the state policed mercantilism.⁴²⁹ In America, patent proprietors and irregular doctors could operate quite easily through the medical marketplace. Such liberalism in the medical marketplace is perfectly illustrated by an article published in the penny paper *Pennsylvania Public Ledger* in the 1830s. In response to a letter castigating the editor for carrying an advertisement for a known nostrum remedy, the newspaper retaliated with the following statement,

Some regular physician in want of patients complains of us for advertising what he calls *quack* medicines....Brandreth's Pills!! We have frequently said that while our editorial columns were not to be bought, or controlled by any by ourselves, our advertising columns were open to any who would pay for them.⁴³⁰

It has been suggested that the expansion of the patent medicine market owed much to the proliferation of a popular press.⁴³¹ Porter therefore notes, that unlike Europe, the United States was well suited to quackery: 'congress accepted no responsibility for medical licensing or policing, and state legislatures had small reason to [prohibit] medical sects' or irregulars in the 'new nation's anti elitist atmosphere'.⁴³² Moreover,

⁴²⁷ Susan Klepp, 'Lost, Hidden or Obstructed: Contraceptive and Abortive Technology in the Early Delaware Valley', in Judith A. McGaw (ed.), *Early American Technology: Making and Doing things from the Colonial Era to 1850* (Chapel Hill: University of North Carolina Press, 1994), 71.

⁴²⁸ Lisa Rosner, 'The Philadelphia Medical Marketplace', in John Harley Warner and Janet A. Tighe (eds.), *Major Problems in the History of American Medicine and Public Health* (New York: Houghton Mifflin Company).

⁴²⁹ George Rosen, 'Cameralism and the Concept of Medical Police', *Bulletin of the History of Medicine*, Vol.27, No.1 (1953), 21-42.

⁴³⁰ PPL, 20 Sep. 1837.

⁴³¹ James Harvey Young, 'American Medical Quackery in the Age of the Common Man', *The Mississippi Valley Historical Review*, Vol. 47, No. 4 (Mar. 1961), 585.

⁴³² Porter, *Benefit of Mankind*, 355,

historians also suggest that Pennsylvania was home to a larger and more competitive medical market than any other state.⁴³³

In early national Philadelphia patent remedies took off as a highly marketable commodity, and the commercialisation of domestic medicine flourished in an individualistic climate where preparations were cheaply manufactured. Those who practiced outside the regular medical profession were freely able to sell their anti-venereal medicines making them easily affordable. Whether wealthy or pauper, the sick could purchase from the growing numbers of dispensing druggists opening shop. Such druggists advertised their stocks to medical providers and the common man through a variety of mediums, including newspapers, but also shop facades.⁴³⁴ Apothecary stores were not the only outlets where medicines could be purchased. Grocers and booksellers were also constantly stocked with the latest medicinal ingredients, patent remedies as well as medical and surgical sundries.⁴³⁵ Therefore, as the colonies expanded, commercial medicines became widely available in response to demand. By the mid-1790s, druggists were consistently listed in city directories, and although these sources are not comprehensive they do provide a good indication of the services available.⁴³⁶

Sick Philadelphians were able to access a range of home-grown herbal ingredients and drugs, as well as medicines and medical equipment imported from Europe. Pennsylvania was home to a significant German community. Despite the Cameralist regulations characteristic of their native territories, Philadelphia traders participated in a lively trans-Atlantic exchange of European pharmaceuticals and medical technologies.⁴³⁷ Moreau de St. Mery illustrates the assimilation of French commodities, such as surgical instruments for instance. The French visitor opened a bookstore in Philadelphia 1794 and commented in his journal, ‘syringes, when first

⁴³³ Renate Wilson, *Pious Traders in Medicine, a German Pharmaceutical Network in Eighteenth Century North-America* (Pennsylvania State University Press: Philadelphia, 2000), 162.

⁴³⁴ *Ibid.*, 103.

⁴³⁵ Gregory Higby suggests that early American apothecaries operated more as manufacturers and wholesale suppliers than as retailers, thus medicines were more commonly bought by the general public from booksellers, general stores and other merchants. Gregory Higby, ‘From Compounding to Caring: An Abridged History of American Pharmacy’, in Calvin H. Knowlton, Richard P. Penna (eds.) *Pharmaceutical Care* (New York: Chapman and Hall, 1996), 21.

⁴³⁶ For a discussion on utilizing city directories as historical evidence, see Haggerty, *Atlantic Trading*,

⁴³⁷ Wilson, *Pious Traders*, 100-1.

imported by French colonists seemed like a hideous object', yet he remarked, 'later they were put on sale by American apothecaries'.⁴³⁸ Thus, despite the rampant disease and sickness permeating the immigrant city, a sick American could do worse than find himself in Philadelphia, the crucible of medicine. Moreover, venereal disease constituted a profitable business in America's national market, as it was in Britain.⁴³⁹ In fact the Philadelphia marketplace emerges as a battlefield, as unqualified practitioners competed in a terrain that was explored by many infected Philadelphians in search of the most rapid and reliable (and often, cheapest) remedy.

4.3 Domestic Medicine: Plants, Vegetables and Sarah Waln's Kitchen

Lay medical knowledge was extensive, and historians suggest domestic medicine and folk healing may well have exceeded orthodox medicine until well into the nineteenth century.⁴⁴⁰ Americans still healed themselves in their own homes, relying on the advice available in almanacs, books and pamphlets, as well as counsel from practitioners operating throughout the city's neighbourhoods. Booksellers sold the latest domestic medical guides, which emerged as a lucrative business and an important resource for self-treatment.⁴⁴¹ Rosenberg suggests the late colonial and antebellum periods were a 'kind of golden age' for self-healing., with medical guides and texts widely owned, many being transported from Britain to an undeniable market.⁴⁴² Furthermore, from the 1790s the American medical profession touted home-grown medical texts to replace those that were imported, the most influential

⁴³⁸ Roberts, *American Journey*, 314-15.

⁴³⁹ The historiography of venereal treatment specifically and the marketplace is more extensive for Britain compared with America, where it is relatively untouched aside from James Harvey Young's contributions. For a discussion of the marketplace and venereal disease in Britain see Roy Porter, 'Laying Aside any Private Advantage: John Marten and Venereal Disease', and Philip K. Wilson, 'Recognizing and Treating Syphilis in Daniel Turner's London', in Merians, *Secret Malady*, 51-65; Kevin Siena, 'The Foul Disease and Privacy: the Effects of Venereal Disease and Patient Demand in early Modern London', *Bulletin of the History of Medicine*, Vol.75, No. 2 (2001), 199-224. The literature on France is likewise vast. See for instance Susan Connor, 'The Pox in Eighteenth Century France', in Merians, *Secret Malady*, 15-31. These works attend to the medical marketplace from the perspective of wealthier customers. For a particularly insightful perspectives of treatments in the private sphere see, Jill Harsin, 'Syphilis Wives and Physicians: Medical Ethics and the Family in Late Eighteenth Century France', *French Historical Studies*, Vol. 16, No. 1 (1989), 72-95.

⁴⁴⁰ Wyke, T.J., 'Hospital Facilities for and Diagnosis and Treatment of Venereal Disease in England, 1800-1870', *British Journal of Venereal Diseases*, Vol. 49, No. 1 (1973), 81; Fissell, *Patients, Power*, 39.

⁴⁴¹ John Duffy, *The Healers: A History of American Medicine* (Urbana: University of Illinois Press, 1979), 126.

⁴⁴² Charles E. Rosenberg, 'Health in the Home: A Tradition of Print and Practice', in Charles Rosenberg (ed.) *Right Living: an Anglo American Tradition of Self-Help Medicine and Hygiene* (Baltimore: John Hopkins University Press, 2003), 7; John Parascandola, *Sex, Sin and Science, A History of Syphilis in America* (Westport: Praeger, 2008).

having been William Buchan's *Domestic Medicine*.⁴⁴³ These books were held to be a fundamental source of household therapeutic information, and 'from the very first page...US writers sought to make explicitly clear to their readers that their work was specifically designed for an American audience'.⁴⁴⁴ While there were certainly medical practitioners of botany in Europe, Gevitz contends the most notable and nationalistic feature that set American manuals apart from European ones lay 'in the touting of botanicals natives to their own country'. Thus Americans -both lay and professional- tended to be more receptive to herbal remedies than their British counterparts.⁴⁴⁵

A large number of these texts also pertained to medical control of venereal disease, often referred to as the "secret malady". Of course some impoverished diseased women were illiterate, but prostitutes were surely one group who shared the information available from these works. There were a variety of ways a woman could play her own therapeutic role, and without doubt, prostitutes suffering from venereal disease attempted self-medication and home healing. The nineteenth century physician William Acton confirmed that prostitutes in England often attempted to cure themselves. They would wash the site of the poison with alcoholic and astringent solutions like vinegar then apply caustics in an effort to destroy the poison.⁴⁴⁶ American prostitutes by contrast may have turned to alternative botanical therapy, recourses not normally as popular or widely available to most European lower class prostitutes.

Although mercury was held to be the foremost cure for venereal diseases in the eighteenth century, historians agree its ineffectiveness and gruesome side-effects had caused concern on its safety for centuries.⁴⁴⁷ Philadelphia's sick community had recourse to a variety of plant-based medicines such as guaiacum, sassafras, sarsaparilla, ipecac and Peruvian bark.⁴⁴⁸ With the Greek revival in Europe from the late eighteenth century, 'physicians became concerned that the remedies then in use

⁴⁴³ Norman Gevitz, 'But all those authors are foreigners: American Literary Nationalism and Domestic Medical Guides', Roy Porter, (ed.) *The Popularisation of Medicine, 1650-1850* (London,: Routledge, 1992), 239-44.

⁴⁴⁴ Ibid.

⁴⁴⁵ Gevitz, 'But all those authors', 243-5.

⁴⁴⁶ Walkowitz, *Prostitution*, 52.

⁴⁴⁷ Marie E. McAllister, 'John Burrows and the Vegetable Wars', in. Merians, *Secret Malady*, 87

⁴⁴⁸ Guaiacum was believed to reach parts of the body mercury could not reach. Hayden, *Pox*, 49.

were inferior, and sought to recover the original *materia medica* used by the ancients'.⁴⁴⁹ Europeans perceived syphilis to be a New World disease, leading many to conclude that the cure should be found where the disease originated, giving American plants increased credibility as a cure.

These plants were accordingly commercialised. Guaiacum was a time-honoured specific for syphilis and from the fifteenth century was 'imported into Europe at staggering prices'.⁴⁵⁰ Yet, the efficacy of guaiacum was questioned and it was in decline by the late eighteenth century. This was replaced by other woods and roots, the most notable anti-syphilitics being ipecac, sarsaparilla and sassafras, all of which grew abundantly in the Americas. Benjamin Ellis's *Formulary* noted Sarsaparilla as being 'long celebrated' in the treatment of syphilis, as well as 'the disease produced by the improper exhibition of mercury'.⁴⁵¹ Sassafras had been exported from New England to Britain from first settlement, and a thriving market was sustained for a long time. According to Charles Manning and Merrill Moore, 'London needed sassafras...and the market was a lively one as long as the healing powers of it were believed in'.⁴⁵² This point is especially pertinent: American doctors and druggists purchasing wholesale were supplied in abundance with barks and other natural products specific to venereal diseases.

Such natural cures were often associated with Native Americans. A Southwark irregular doctor passed remark on an advertisement in his local newspaper by a German, a doctor who had, 'spent two years on the Plains acquiring knowledge of Indian medicine...and [was] prepared to treat all diseases with vegetable remedies alone'.⁴⁵³ Philadelphians were therefore well aware of the healing properties of plants

⁴⁴⁹ Porter, *Benefit of Mankind*, 191.

⁴⁵⁰ Guaiacum had its roots so to speak in the West Indies, and many practitioners believed it could cure venereal diseases by acting on its own. Bynum, 'Wages of Sin', 17. John Parascandola, *Sex, Sin and Science, A History of Syphilis in America* (Westport: Praeger, 2008), 18.

⁴⁵¹ Ellis, *Formulary*, 89. As chapter six will show these were regularly stocked in the almshouse apothecary store.

⁴⁵² Allen, *Wages of Sin*, 55. In the early sixteenth century the sassafras root commanded high enough prices for two commercial ventures with boats sailing on special voyages to New England from Europe. Charles Manning and Merrill Moore, 'Sassafras and Syphilis', *New England Quarterly*, Vol. 9, No.3, (1936); 473-475.

⁴⁵³ S. Weir Mitchell, M.D., *Autobiography of a Quack* (New York: Century Company, 1900), 67. It should be noted that this is a fictional work that appeared in the *Atlantic Monthly* as an anonymous contribution in the mid-nineteenth century. Yet the story has been noted as an important account. The author Silas Weir Mitchell was a Philadelphia physician who held important hospital appointments. He

derived from their native pharmacopoeia, passed down through popular lore by the American Indians. While these remedies often came in 'black horrible concoctions', Americans were attuned to the beneficial qualities of vegetable and plant-based medicines.⁴⁵⁴

Pills and potions that were supposedly plant-based non mercurials were sometimes quite expensive to the common man or woman who bought on a small scale. However, some diseased women knew one place where they might acquire such remedies free of charge. The importance of herbs and barks cannot be overlooked and as we shall see in chapter six, almshouse doctors relied heavily on them. Almshouse physicians and apothecaries frequently requested woods such as Red Sarsaparilla as seen in their medical lists sent to the managers. Prostitutes who went to the almshouse were able to reap the benefits of botanical medicine, while their European counterparts were not so lucky. Nor were diseased women who exploited the marketplace to its fullest before turning to the infirmary for help.

Collecting herbs to make into domestic medicines was commonplace in early America, and the above-mentioned plants were kept in Philadelphia kitchens. Although fewer city dwellers had access to gardens given greater population density, the existence of recipe-book manuscripts containing therapeutic and pharmacological information lays testament to an array of ingredients and herbs kept in the kitchen cupboards of American women.⁴⁵⁵ These women would have either directly sold their homemade medicinal wares to individuals as cooking, prophylactic or curative purposes, or they may have sold in bulk to medical men and women as part of their domestic economies.

contributed widely to neuroscience being considered as one of the greatest Americans of that field. Moreover, he observed how the sick poor community around him were exploited by quacks, thus his work is considered as a valid cautionary tale that closely related Philadelphia's wider medical marketplace. As one author notes, Mitchell's 'professional knowledge enabled him to write authoritatively' and this literary tale was his 'most thorough' work. Carl Van Doren, *The American Novel* (Hesperides Press, 2006), 221.

⁴⁵⁴ Lawell, 'Apothecary Shops', 241.

⁴⁵⁵ Klepp, 'Lost, Hidden Obstructed', 92. For a discussion on the use of these sources to interpret lay medicine in early modern Europe and the close relationship between commercial and domestic medicine, see, Elaine Long and Sara Pennell, 'Recipe Collections and the Currency of Medical Knowledge in the Early Modern Marketplace', in Jenner and Wallis (eds.) *Medicine and the Market*, 133-49.

It would seem lay folk held a considerable amount of medical knowledge on individual diseases and their treatments. We know this from the survival of sources exemplifying local knowledge of home-grown botanic and vegetable ingredients, and Sarah Waln has left a rare household recipe collection. Her book contains directions for cures illustrating that plant based medicinal recipes were commonly kept on hand for healing purposes.⁴⁵⁶ Moreover, these ingredients were relatively easily acquired. The manuscript illustrates the scope of medicinal knowledge and practical know-how carried out in the domestic setting, and includes recipes for a variety of bitters, pills, powders and plasters. Waln's book contains sets of remedies for mostly non life-threatening ailments, and information on a variety of drugs.

Many of the ingredients appearing in Waln's kitchen cupboard were well-established in the traditions of native herbal healing, and some of these were well known as venereal treatments. Sarah grew 'sassafras roots ...liquorice...myrrh [and] jalap' in her garden. She was also quite clearly able to procure 'guaiaicum...sarsaparilla' and 'Jesuits Bark'. Her book includes directions for cures for a host of ailments, from dropsy, convulsion, coughs, ulcers, the bloody flux and 'a recipe for a gentle purge' using cream of tartar. Waln also noted directions on making tinctures and ointments from base ingredients, such as 'Elixir of Vitriol...Jesuits Bark...Cream of Tartar...Indian medicine for sore eyes', which included 'a pinch of sassafras' and also 'Dr. Dover's excellent cure for the Itch (ipecac)'. Interestingly, Sarah's recipes contained prescriptions known to ameliorate the symptoms of the pox, such as directions to make 'Balsam of Guaiacum...for the patient suffering from...Gleets [early stage gonorrhoea]'. Sarah mentioned remedies 'useful in gleets' on several occasions, suggestive that the venereal infection may have inflicted one or more of the men in her family, or even customers if she did engage in wider production.⁴⁵⁷ Above all, it is clear that Philadelphian's were able to procure a variety of readily accessible botanical ingredients, many of which were known for their special properties in curing stages of venereal infection.

⁴⁵⁶ Sarah Waln, 'Recipe Book 1800', HSP. Also see Eliza Farmer, Letterbook, 1774-1789, HSP.

⁴⁵⁷ Waln, Recipe Book. British historians refer to many of the ingredients pertained to in Waln's book as 'exotics', which were less readily accessible. Leong and Pennell, 'Recipe Collections', 136.

It is not clear if Waln actually produced medicines solely for use in the private sphere, or for economic exchange on a small commercial scale but it is likely that she may have engaged in production in the public sphere for philanthropic ends.⁴⁵⁸ Moreover, Waln indicates that recipes -both culinary and medicinal- were shared amongst friends and family, and were circulated and passed down through generations. For example, 'for the dropsy' Sarah obtained her recipe 'from Sarah Logan who had it from Wright's family'.⁴⁵⁹ Such family recipes were also used by apothecaries in their drug stores as well as lay healers.⁴⁶⁰ Domestic practices based on herbs gathered from women's gardens were soon replaced by commercial preparations.⁴⁶¹ Although Sarah Waln was drawn from the upper echelons of society, her recipe book represents an approach to healing which may have been customary in the early republic. Waln's medical knowledge was no doubt typical of those acting as medical healers in the marketplace, the men and women who made it their business to acquire equipment, ingredients and knowledge to make their medicinal wares and services commercially available. Simply put, although some Philadelphia women acquired a wealth of information on medicinal ingredients, most people had at least some rudimentary knowledge on recipes for domestic healing. Fissell has shown that medical knowledge was a significant feature of plebeian culture, and thus, 'patients had a wealth of concepts and remedies upon which to draw'.⁴⁶² There was a basic understanding and 'repertoire of recipes and knowledge', much of which was based on age-old botanical information passed down by oral tradition.⁴⁶³ Yet, it is important to note that in the city environs without extensive gardens, the majority of folk did not practice domestic medicine to any great extent, and instead resorted to ready-prepared medicines from healers or apothecaries.

However, there was a problem for all customers who shopped for herbal medicines to treat their venereal complaints. One special ingredient was added to most mixtures,

⁴⁵⁸ Leong and Pennell also show that making medicine was a common pastime for Christian women and was expected as part of their religious duties. Leong and Pennell, 'Recipe Collections', 135.

⁴⁵⁹ Waln, *Recipe Book*.

⁴⁶⁰ Higby, 'Compounding to Caring' 21.

⁴⁶¹ Klepp, 'Lost, Hidden and Obstructed', 89

⁴⁶² Mary Fissell, 'The Disappearance of the Patient's Narrative and the invention of Hospital Medicine, in, ed. R. G. French and A. Wear, *Medicine in the Age of Reform* (Oxon, Routledge, 1991), 93.

⁴⁶³ Rosenberg, 'Health in the Home', 5.

even those medicines which incorporated Native American herbs. As Rosenberg notes, although,

...many lay people had some understanding of medical remedies...which were universally accessible to anyone who could gather herbs or pay the pharmacist or shopkeeper...There were no restrictions on the purchase of...highly toxic mercury, arsenic, and antimony compounds.

In Philadelphia's medical marketplace, mercury was given to diseased customers as a blanket remedy, despite the claims of those who contended their potions did not contain the poison, which will become clearer below.

4.4 Reconstructing Medical Networks in Lydia and Sarah's Southwark Neighbourhood

Thus far, we have seen that recourse to medical treatment was readily accessible to a prostitute or diseased woman. If she lived within the brothel setting, she may have been made familiar with the range of options available by her counterparts. Historians have also suggested it was common practice for physicians to make house calls to brothels.⁴⁶⁴ However it is likely only the higher grade establishments qualified for this type of service. For those who drew their clientele from one of Philadelphia's many lower grade brothels and taverns, or for those who serviced their clients in one of the many dark alleyways, there were options available, which did not involve resorting to institutional medicine. If self-treatment did not appeal, recourse to one of the city's many medical practitioners was an alternative for diseased women. There were a host of practitioners plying their wares and services in late eighteenth century Philadelphia.⁴⁶⁵ Moreover, despite the fact the numbers of qualified grew substantially in Philadelphia, they were eclipsed by the 'self-styled' doctors, and the 'Cuppers and Bleeders...Midwives and Nurses' who flourished in the city.⁴⁶⁶ Aside from confirmed or qualified medical folk who appear in the city directories, lay providers swarmed the medical market in the city's suburbs, most of whom remain hidden from the historian's view. Thus we know little of their identities, let alone their activities and responsibilities.

⁴⁶⁴ Cohen, *Murder of Helen Jewett*, 105.

⁴⁶⁵ Lisa Rosner, 'Thistle on the Delaware: Edinburgh Medical Education and Practice, 1800-1825', *Social History of Medicine*, Vol.5, No.1 (1992), 19, 27-9.

⁴⁶⁶ Ibid.

Brothel madam Lydia Oakman, and prostitute Sarah Thompson, lived in an area swarming with medical practitioners, who most likely served as vital recourse to diseased women and the sick population at large. There was certainly a community of practitioners or healers that provided clients with their services around the alleys and streets of working class neighbourhoods. Prostitutes and diseased women depended on this network of medical providers, and conversely, those carrying out their trades in the alleyways and narrow streets of Southwark and the Northern Liberties depended on diseased women. Rosner suggests geographic distribution of medical providers was uneven, and gender predicated the location of a healer's practice. Thus, male practitioners -physicians, cuppers and bleeders, surgeon-barbers and apothecaries- tended to practice on the wider main streets of the city's thoroughfares. Conversely, female practitioners tended to congregate in the alleys or narrow cross-streets on the fringes of the city. Women like Lydia Oakman and Sarah Thompson would almost certainly have lived close to a 'nurse', 'midwife' 'bleeder with leeches' or 'doctress'.⁴⁶⁷

Women played a significant role in the marketplace both as consumers and traders in all sorts of goods. Traditionally care of the sick was a woman's prerogative, and it was only natural that a woman suffering from a disease inflicting her private parts would seek female therapeutic advice. Women occupied an important place as part of Philadelphia's health care providers and it is likely they positioned their businesses close to their clientele. However, the majority would not be included by those who compiled the city directories, and thus remain under-represented in the broader context of Philadelphia's recorded medical practitioners. These 'invisible' urban medical women plied their business in the alleys and cross streets of Philadelphia, where streetwalkers and brothel prostitutes commonly congregated.⁴⁶⁸ Although we can safely assume that diseased women recognized and embraced such medical women as crucial providers of medical care, we cannot be sure how they were perceived by male doctors. Most likely they were acknowledged as providing certain

⁴⁶⁷ Rosner, 'Thistle on the Delaware', 29.

⁴⁶⁸ On women's participation in the marketplace, see Wulf, *Not all Wives*, especially chapter four; On medical women, see Rosner, 'Thistle on the Delaware', 27-9. For the role women played in early modern London as providers and consumers of medical products, see Deborah E. Harkness, 'A View from the Streets: Women and Medical Work in Elizabethan London', *Bulletin of the History of Medicine*, Vol. 81, No. 1 (2008), 52.

services, although to what degree they were regarded as legitimate is uncertain. From the professional's viewpoint medical women were most likely accepted as long as they kept firmly in their place: down the streets and alleys of working class neighbourhoods as part of the wider commercial healers, and certainly not as part of the regular medical community. In this regard ex-almshouse physician Agnew's views are revealing. It is best left to the doctor himself to explain as he looked back during the late nineteenth century on the history of the almshouse.

The year 1810...furnishes us with the first instance...of a hospital in this country receiving a female resident physician...a Mrs. Lavender made application to be admitted...in order to perfect her education. Such a charming name as "Lavender" so overcame the physical senses of the board, that they lost their intellectual senses and granted her petition.⁴⁶⁹

Mrs. Lavender had her place, and it was not in the hospital setting where professionals carried out their trade. The chances are that Mrs. Lavender was perfecting her skill as a midwife.⁴⁷⁰ At worst, Agnew's views can be taken as nothing short of misogyny, yet most probable his statement is representative of Victorian male ideas of women's place. According to such a view, a woman's place as a healer was either in the home, or out of sight tending to the sick in neighbourhoods of the poor. In any case, at these locations women of the lower sort could seek advice on venereal treatment, and other occupational hazards associated with prostitution, including unwanted pregnancy. A diseased woman suffering from gonorrhoea already had her chances of becoming pregnant reduced, because the infection caused sterility.

Knowledge of birth control practices were in place by the late eighteenth century. Moreover, there was a significant market for abortifacients and drugs known for their contraceptive properties. According to Rowe and Marietta, abortifacient herbs, as well as more violent remedies were used both 'successfully and surreptitiously' in the eighteenth century.⁴⁷¹ Moreover, contraceptive technologies were sold in drug stores

⁴⁶⁹ Agnew, 'Medical History', 12.

⁴⁷⁰ For a concise discussion on the admission of women to medicine, see Porter, *Benefit of Mankind*, 356-358.

⁴⁷¹ G.S. Rowe and Jack D. Marietta, 'Personal Violence in a Peaceable Kingdom, Pennsylvania, 1682-1801', Christine Daniels and Michael Kennedy (eds.) *Over the Threshold: Intimate Violence in Early America* (Routledge, New York, 1999), 32. Stansell has also indicated that recipes for abortifacients were commonly circulated amongst prostitutes in nineteenth century New York.

and booksellers as standard practice by the 1790s.⁴⁷² Wilson has also suggested midwives, herbalists lay healers were recognized and consulted for their knowledge and expertise in attending to abortion and dead fetuses. She illustrates this with an example of the large German Pennsylvanian community who provided the medical marketplace of Philadelphia with herbs known for their contraceptive and abortive properties.⁴⁷³ Abortions were carried out by male physicians as well as women acting on their own, at all social levels. Dayton proposes that ‘the activity was associated with lewd or dissident women’ and thus may have been more common than we realise.⁴⁷⁴ If one lay group were likely well-versed in birth control or abortion strategies, then prostitutes were surely familiar with them, however unsure, ineffective or harmful they might be. Although the rate of abortion is impossible to determine, one New York physician calculated that 20 percent of that city’s pregnancies were terminated, and that ‘prostitution largely contributes to this crime’.⁴⁷⁵ It is possible that Lydia Oakman attempted to terminate an unwanted pregnancy. In 1803 she was admitted to the almshouse suffering from amenorrhoea, a known side-effect of abortion.⁴⁷⁶

We should return to Lydia and Sarah’s Plumb Street neighbourhood in Southwark to find what medical services were likely available here. If Sarah and Lydia preferred self-treatment, they may have shopped at Geraldus Stockdale’s grocer store located a number ‘6 Plumb Street’.⁴⁷⁷ Here they may have found patent medicines or ingredients to make their own drugs to treat venereal disease, or even emmagogues

⁴⁷² Janet Farrell Brodie, *Contraception and Abortion in Nineteenth Century America* (New York: Cornell University Press, 1994), 33, 42, 50.

⁴⁷³ Wilson, *Pious Traders*, 64, 71-75. Also see Barbara Kean, ‘The Use of Herbal Birth Control among Native American Women’, *Native American Healing*, Vol. 81 (1977). Also see Klepp, ‘Lost, Hidden and Obstructed’. 89.

⁴⁷⁴ Cornelia Dayton, ‘Taking the Trade: Abortion and Gender Relations in and Eighteenth Century New England Village’, in ed. Judith Walzer Leavitt, *Women and Health in America* (Madison: University of Wisconsin Press, 1999), 12, 30. According to Hill, by the mid-nineteenth century in New York, ‘almost every form of birth control method used today existed in some rudimentary form...with the notable exception of course of the contraceptive hormone pill’. Hill, *Sisters Keepers*, 235. That this was the case is attested to by state legislatures’ attempts to suppress the activities of abortionists. Roger Lane, *Violent Death in the City: Suicide, Accident and Murder in the Nineteenth Century Philadelphia* (Mass: Harvard University Press, 1979), 91.

⁴⁷⁵ New York social reformer Malcolm Macdowall also made similar conclusions a quarter of a century before Sanger. Hill, *Sisters Keepers*, 238.

⁴⁷⁶ 25 Mar. 1803, Almshouse Hospital Apothecaries Register of Sick and Surgical Wards, 1800-1803.

⁴⁷⁷ Clement Biddle, *Directory for 1791*; Robinson, *Philadelphia Trade Directory for 1803*. All the medical practitioners mentioned are included in the Directory, except the fictional Dr. Sandcraft. The spelling of ‘Plumb’ is used in the sources interchangeably. In the 1791 Directory it was denoted as ‘Plumb’ yet in the 1803 Trade Directory, ‘Plum’ was used.

and abortifacients to expel a fetus. Or they may have preferred to visit a female grocer such as Margaret Tatem, whose shop was located round the corner from their Plumb Street residences at number '80 Shippen'. If they had enough money, Lydia and Sarah may even have visited Joseph Goss, a male physician who lived a few doors up from Stockdale's grocer store at number '10 Plum'. Alternatively -as we have seen- Jane Hemphill who lived at number '73 Plum' Street may have helped the diseased women in her capacity as a midwife. The women no doubt preferred to keep their infections secret. Thus, they might have made a surreptitious trip to the outskirts of Southwark to seek out the medical services provided by Mrs McCabe, a midwife who resided in the Passyunk fringe district of the city at '241 S. Sixth St'.

Across town in the similarly impoverished Northern Liberties, Mary Carlisle also had recourse to a variety of healers. During a three-year hiatus of almshouse treatment she may have sought help from Jane and Anne Rose, both midwives living at numbers 7 and 9 Brewers Alley. Or there was always Ann Emes whose midwifery services were available in the raucous Sassafras Street area. Despite the growth of man-midwifery, female midwives still played a crucial therapeutic role in the community, providing expertise in other areas as well as delivering babies. Such female healers are visible from the mid-eighteenth century plying their trade in Philadelphia's northern districts as illustrated in local newspapers. The *Pennsylvania Gazette* announced that 'Mrs Brown' of Sassafras Street provided treatment for the "King's Evil" (scrofula) in addition to other services.⁴⁷⁸ Nurses are also visible in the directories. By all appearances Mary Carlisle would also have had recourse to several nurses, given that they appear to have congregated in the northern sections of the city, such as Eliza, a nurse whose location was in Callowhill. As noted in chapter three, Mary often turned up in the southern districts of the city where Lydia and Sarah resided. It is probable she was familiar with a range of providers throughout the city given that she suffered from venereal disease for a considerable time. In Southwark they may have sought medical help at Rachel Guiy's residence at '29 Plumb' Street. More than likely Lydia, Sarah and Mary did all they could to avoid Hannah January who lived in Smith's Alley. Hannah is noted in the Trade Directory as 'layer out of the dead'. Despite the inclusion of midwives in the Directories, female healers' presence and agency

⁴⁷⁸ *Pennsylvania Gazette* quote taken from Lyons, *Sex among the Rabble*, 113.

remains hidden from the historian thus we can only speculate.⁴⁷⁹ Sarah and Lydia may also have turned to male apothecaries. Dr Sandcraft the Southwark ‘quack’ complained his business was threatened by numerous apothecaries, and he was particularly riled by,

a stout little German, with great silver spectacles sat behind the counter containing numerous jars of white powers labelled concisely ‘lac’...’opi’...’pulvs’ etc, while behind him were shelves filled with bottles containing what looked like minute white shot.⁴⁸⁰

Women like Lydia, Mary and Sarah therefore had access to a range of healers in their community. Dr. Sandcraft described the neighbourhood where he attempted to trade as being ‘on the skirts of a good neighbourhood...below it lived a motley population...among which I expected to get my...first patients’. The street where his premises was located was ‘filled with grog shops, brothels, slop shops and low lodging houses’ where a local could ‘dine for a penny on soup [and] be drunk for five cents’. Moreover, even those who could barely scrape a living together seemed able to procure the extra dime to purchase medicine. The ‘bulk’ of Sandcraft’s patients were ‘soap-fat men, rag pickers, oystermen’ and others ‘with nameless trades, men and women, white and black and mulatto’. These sick paupers were ‘too poor to indulge in uptown doctors’, yet he remarked with surprise, ‘how they got the levies, flips and quarters with which I was reluctantly paid I do not know.’ Significantly though, ‘they expected to pay, and they came to me in preference to the Dispensary doctor’ who seemed always too busy ‘in the lanes and alleys around us’ to cater for the entire sick population of the neighbourhood.⁴⁸¹ It is indeed possible then that some of our diseased almshouse women called upon a practitioner fitting Sandcraft’s description.

As chapter one outlined, Sarah Thompson was left near-destitute by her husband when she sought almshouse medical care 1811. Once restored to health she was sent from the infirmary to the Magdalen Asylum, after which she disappeared from the records. Perhaps she still acted as a prostitute, or alternatively she may have returned

⁴⁷⁹ Martha Ballard’s diary remains a unique source detailing the work and life of an early American midwife. Unlike Philadelphia midwives, Ballard practiced in rural Maine, and visited her patients at their homes for the most part. Laurel Ulrich, *A Midwife’s Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Knopf, 1992).

⁴⁸⁰ Mitchell, *Autobiography of a Quack*, 46.

⁴⁸¹ Ibid. 15-18.

to work as a domestic servant. While it is impossible to confirm Sarah's whereabouts, if she did become ill again she certainly did not return to the almshouse. Yet, she may indeed have turned to the Southern Dispensary, which was located very near the area Sarah was already familiar with. From its inception in 1816, the dispensary was 'originally located on Shippen Street, above Third', thus very close to Sarah's prior Plumb Street residence.⁴⁸² If Mary, Sarah and Lydia preferred a quick-fix remedy rather coming face-to-face with a practitioner there were indeed other potions.

4.4 Charlatans, Miracle Cures and the Venereal Philadelphian

Diseased women were confronted with a considerable choice of patented remedies in a city where the market abounded with pills and potions all alleged to cure the secret malady. If not poor, a brothel madam like Lydia Oakman with a few dollars to spare may have made her way to William Delaney's downtown drug store on Second Street, where she could procure 'Dr. Rush's...Mercurial Sweating Purges'. If she wanted to keep her disease secret (or that of one of her brothel workers) she could easily have left her Plumb Street brothel residence in Southwark and headed into the south end of the city proper where this drug store was located.



Figure 3: William Birch, Southeast Corner of Third and Market Streets, Philadelphia, 1799. Delany's store was located round the block from this corner.

⁴⁸² 'Charter of Incorporation and Rules and Regulations for the Southern Dispensary for the Medical Relief of the Poor', Aug. 1816, PHA.

Alternatively, she could have headed even deeper into the city where she would come across the premises owned by George Abbot, ‘Apothecary and Druggist’ at ‘85 Market Street’. She may also have used this outlet to purchase substances made from Balsam of Copaiba, Tincture of Guaiacum, Peruvian bark, aloes, Seneca snake-root and myrrh, all supposed to be successful in preventing or terminating unwanted pregnancy. Abbot sold an assortment of patent medicines such as ‘Hoopers Female Pills’, ‘Keyser’s Pills’ and ‘Hill’s Balsam of Honey’. These drug stores also sold Jesuit’s Anti-venereal Drops, Jalap, Opium, Cream of Tarter and Harvey’s Sarsaparilla Syrup all believed to be particularly useful for their suppression of venereal symptoms. Lydia may have purchased ingredients in large quantities to make remedies herself to dispense to those prostitutes who resided with her. It was in Lydia’s best interests to have a healthy workforce. Sharp and Delaney sold wholesale ‘on moderate terms’ many ingredients used as venereal cures, including ‘Arsenic alb’, ‘Calomel’, ‘Jalap’, ‘Camphor’, ‘Caustics of all kinds’ Balsams’, ‘Mercury’, ‘Quicksilver’, ‘Cinnabar’ and ‘Barks’. Fortunately for Lydia, all came ‘with proper directions’. Delaney’s drug store was just one of Philadelphia’s numerous suppliers of patent medicines advertised daily in the local newspapers. Delaney and Abbot’s stores likely attracted a wealthier clientele.⁴⁸³ Yet there were more affordable drug outlets in the city providing for sick Philadelphia residents of all social classes. However, if Lydia had taken this route she was not so lucky with her purchases given that she turned up at the almshouse very sick.

Venereal “cures” were being marketed from the early eighteenth century, and newspapers carried a host of notices implying the diseased customer could obtain mercury very easily in the city.⁴⁸⁴ Doctors (orthodox or irregular), grocers and booksellers publicised their own remedies or ‘miracle cures’ in the local newspapers on a daily basis, as did apothecaries and booksellers. From the mid eighteenth century, newspapers carried advertisements for a range of remedies sold in local apothecary shops, dry goods stores and booksellers. Grocery stores sold drugs in base form or as

⁴⁸³ 9 Nov. 1793, *Federal Gazette and Philadelphia Evening Post*; 20 Mar. 1782, 18 June, 1784, 23 Feb, 1764, 17 Apr. 1799, *Pennsylvania Gazette*.

⁴⁸⁴ For a discussion on newspapers providing the general public with notices pertinent to the treatment of a variety of ills see, William H. Helfand, ‘Advertising Health to the People’, in Charles Rosenberg and William Helfand, *Every Man his Own Doctor: Popular Medicine in Early America*, booklet published by Library Company of Philadelphia (1998). On early modern London venereal advertisements and handbills see Siena, ‘The Foul Disease and Privacy’.

pills, and as Wilson notes, ‘were served by multiple types of unregulated practitioners, including the trained and untrained’.⁴⁸⁵ Thus, in the 1770s, prostitutes may have stumbled upon bookseller Thomas Anderton’s store in downtown Philadelphia, at the ‘lower end of Jersey Market’. Here they could purchase ‘Doctor Saxony’s...specific purging, which cures the lues venerea in all its stages and circumstances whatever in a very short time’.⁴⁸⁶

For those Philadelphia citizens who were diseased (and could read the *Pennsylvania Gazette*), they could head to a bookseller whose shop was located on ‘Fourth Street’. If they were concerned their loved ones would discover their ‘dirty’ secret, or were perhaps frightened by the prospect of mercurial salivation there were options at this location. In return for ‘ready money’ a diseased Philadelphia resident could indulge in the services of a proprietor, who claimed ‘anyone, without hindrance of business...without being salivated, may, in a very short time, be perfectly cured of all sorts of venereal distempers’. Some doctors even presented the customer with privacy, promising to take ‘Patients into his House, and boards and lodges if desired’. Although the physician claimed customers would not be salivated, his suggestion that he would be willing to confine his patients implies those who sought his cures were indeed subjected to toxic doses of mercury carried to salivation.⁴⁸⁷ For those who wished to treat themselves at home, they could purchase ‘small boxes of medicine for the cure of the said disease in all its different symptoms’ from a location ‘next door to the sign of the Jolly Sailor’.⁴⁸⁸

Such was the wide array of early American medical advertisements. Furthermore, although lay medical knowledge was commonplace amongst the literate, as Fissell points out, ‘a passion for pills extended fairly far down the social scale’.⁴⁸⁹ On the one hand, much of Philadelphia’s population remained illiterate. Yet, William Helfand has suggested that ‘signs on the facades of apothecary shops...were advertisements even the illiterates could decipher’.⁴⁹⁰

⁴⁸⁵ Wilson, *Pious Traders*, 102

⁴⁸⁶ 11 Feb., 1771 *Pennsylvania Chronicle*. Many of the newspapers carrying such advertisements included testimonials pertaining to the success of these ‘miracle cures’.

⁴⁸⁷ See chapters five and six for detailed discussions of this procedure.

⁴⁸⁸ 10 Jan. 1749; 11 June, 1767; 3 Mar, 1768, *Pennsylvania Gazette*.

⁴⁸⁹ Fissell, *Patients, Power and the Poor*, 40.

⁴⁹⁰ Helfand, ‘Advertising Health to the People’, 23.

As outlined, the medical marketplace of early Philadelphia swarmed with medical practitioners plying their trade, many offering to cure their patients with remedies that did not contain the toxic mercury. Porter notes that ‘venereal disease remained a fertile seedbed for quackish practices throughout the eighteenth [century]’.⁴⁹¹ Both quacks and respected patent medicine proprietors naturally fed off the panic accompanying an individual’s shameful and stigmatising disease. Privacy was paramount to many a diseased buyer. Despite the increase in the university trained medical community, quackery and ill-educated physicians were as common after 1790 as they had been before the Revolution.⁴⁹² In the early nineteenth century, distrust of the medical profession gave way to a significant decline in the prestige of orthodox physicians and medicine, and by mid-century an American physician could complain,

[about the] very large number of advertising pretenders who offer their services for the treatment of secret diseases; and many drug stores whose main business is derived from a similar source.⁴⁹³

Demand was so high that prostitutes could never be short of a remedy, and this New York physician lamented that the number of cases treated for syphilis by ‘charlatans’ was a far greater number than those treated by qualified physicians.⁴⁹⁴ A mid-nineteenth century Philadelphia almshouse physician likewise grumbled that, ‘the people of 1796 were not proof against charlatan imposition...every age has had some crotchet on which to betray mental imbecility’.⁴⁹⁵

Promotional handbills existed in early modern London, suggestive that syphilitic customers could purchase medicines in coffee-houses and ale-houses.⁴⁹⁶ The same was true in Philadelphia, and diseased women could seek out quack medicines in coffee houses, local tippling establishments and taverns. For instance, Evan Jones, a self-appointed ‘chymist’ could be found at the Paracelsus Head in High Street, Philadelphia’. Jones claimed that, ‘any persons unhappy under the care of those

⁴⁹¹ Porter, *Health for Sale*, 155.

⁴⁹² Bell, *Colonial Physician*, 25.

⁴⁹³ Sanger, *Prostitution*, 93.

⁴⁹⁴ *Ibid.*, 595.

⁴⁹⁵ Agnew, ‘Medical History’, 9.

⁴⁹⁶ Kevin Siena, ‘The Foul Disease and Privacy’, 212.

unskilful in the venereal disease....may apply to obtain speedy relief from a specific medicine of his own preparing'.⁴⁹⁷ Mary Carlisle took a three year hiatus between almshouse admissions. While her infection may have been lying dormant in its latent phase during this period, it is possible she sought alternative treatment. Thus she might have turned to one of the many itinerant irregulars who practiced in the Northern Liberties like those in Southwark. She may have purchased opium, Spanish Fly (cantharides) or Jesuits Bark from the 'Three Jolly Irishmen' a rowdy pub on the corner of Race and Water Streets.⁴⁹⁸ Prostitutes like Mary were especially well placed in the northern outskirts of the city, because the 'largest distributor of "secret" medicines...and panaceas' was based 'at the corner of 2nd and Race Streets'. At this drug store, the owner 'sold to the labouring poor at half the regular price'.⁴⁹⁹ Apothecaries (wittingly or not) situated their stores in locations where prostitutes were known to congregate. Thus, there was a 'Golden Mortar and the Golden Spectacles...between Black Horse Alley and Market'.⁵⁰⁰ The narrow streets and alleys of Southwark were likewise not short of places to obtain medicine from all kinds of medical folk. By the end of the century the availability of patent pills and powders had proliferated considerably, with a good living to be made by those who indulged the public with their miracle cures.

4.5 Cure or Kill: the Devil in Disguise

There was however a problem with such miracle cures. Although their recipes remained undisclosed, many claimed to be free from the mercury. Yet as archaeological-historians have shown, most did contain mercury in varying degrees.⁵⁰¹ However much a producer of patent medicines sugar-coated his remedies, most came at a considerable risk. Druggists and self-styled doctors were generally dictated to by the standard rule that mercury was *the* syphilitic cure. Philadelphia contemporary George Burgin's pamphlet sums up the blanket use of dispensing mercury in Philadelphia's commercial marketplace. Burgin, who kept an 'assortment of the best Drugs, Medicines and...most of the native medicinal herbs' at 'No. 74 Chestnut Street', claimed that for syphilitic customers,

⁴⁹⁷ 19 May, 1737 *Pennsylvania Gazette*.

⁴⁹⁸ Smith, *Lower Sort*, 22. All three drugs were used in the treatment of venereal disease and to assist foetal abortion.

⁴⁹⁹ Lawell, 'Apothecary Shops', 231.

⁵⁰⁰ Ibid.

⁵⁰¹ Quétel, *History of Syphilis*, 88

...the various preparations of mercury are used for this purpose...they are the only medicines that can be depended upon in the cure of Venereal Disease...the Empiric succeeds with no other...he uses them in disguise and too frequently to the serious injury of his deluded patients.⁵⁰²

Despite his own dependence on mercury, Burgin condemned those who routinely dispensed the poison with scant regard for dosage. As he claimed,

Mercury is a giant in medicine and has saved the lives of thousands, but in proportion to its powers, so are the dangers of using it, which should never be done without the direction and care of the Physician.

Burgin's publication was not to promote a patent medicine. Rather, he sought to counsel the safer use of commercially available drugs, to doctors and the general public. Thus, we can take his comments at face value as an illustration of standard practice in the commercial treatment of venereal disease.

For diseased customers, mercurial cures were easily and cheaply available, especially when the preparation was compounded with calomel in its base form. This was the active ingredient contained in the little blue pill (as it was commonly known) that became very popular in the early nineteenth century amongst venereal sufferers on both sides of the Atlantic. The blue pill must have seemed like a wonder drug when it came on the market, but in actuality it was remarkably dangerous. As Hayden remarks, syphilitics 'no longer gleamed with a blue sheen or smelled like a fried potato', the effects so characteristic of mercurial rubs and pills made from distilled quicksilver, corrosive sublimate and other mercurial salts.⁵⁰³ For many doctors and patients it supplanted the external salve as a way of dispensing mercury. Yet, its wonder lay not in its mercurial content but its application to the patient. The dangers were still ever present in the pill, which could often contain very large quantities of calomel⁵⁰⁴.

⁵⁰² George Burgin M.D., *Directions for Administering Medicines in Common Use with a Brief History of the effects they are intended to produce* (Lafourcade: Philadelphia, 1823).

⁵⁰³ Deborah Hayden, *Pox: Genius, Madness and the Mysteries of Syphilis* (Basic Books: New York, 2003), 49. The blue pill was made from mercury, a confection of roses and powdered liquorice. Also see, Wyke, 'Hospital Facilities', 81; Richard Swiderski, *Quicksilver, A History of the Use, Lore and Effects of Mercury* (North Carolina, McFarland & Company, 2008), 120.

⁵⁰⁴ It is suggested Abraham Lincoln was dependent on the blue pill to treat melancholy. Contemporaries suggested the president 'suffered the neurobehavioural consequences of mercury intoxication'. See Norbert Hirschhorn, Robert G. Fieldman and Ian A. Greaves, 'Abraham Lincoln's

Porter claims that ‘calomel appeared in every physician’s bag throughout the nineteenth century’.⁵⁰⁵ It seems that the compound was also kept on the shelves of most drug stores, and it became especially popular in Philadelphia during the yellow fever epidemic, as we shall see in the following chapter. The manuscripts left by apothecaries provide valuable insight as to how venereal patients were dispensed calomel (mercurous chloride) as a matter of routine in the commercial treatment of venereal infection. The evidence indicates that local apothecaries habitually touted mercury to their customers. Respected druggist Warder Morris had a particular remedy for gonorrhoea that was sure to inflame the condition further (which also helps explain why many diseased women arrived at the almshouse displaying signs of acute mercury poisoning). According to the druggist, the ‘injection that never fails if used in time’ consisted of the potentially lethal dose of ‘ten grains of calomel’. In adults, explained Morris, he ‘freely uses 10 and 10’.⁵⁰⁶ Moreover, he also recommended this injection to be given ‘4 times a day’. Morris also made note of an acquaintance of his who treated his diseased patients with a singular dose of ‘calomel 20 grains’.⁵⁰⁷ If this is what diseased women were purchasing on the street, it is little wonder so many turned up at the almshouse practically debilitated.

Many practitioners made their money by promoting mercury as more reliable and less harmful when mixed with other compounds, mostly plant or vegetable in origin. Thus, as Bynum points out, although mercury had been accepted as a specific for syphilis, there was plenty of room for arguments about the best preparations and correct administration. Thus it was easy to allege one’s own remedy (stated or secret) was superior to all others.⁵⁰⁸ Since pills and potions could be prepared in so many different ways, the empiric could easily claim his remedy to be the best cure. Thus, proprietors were able to exploit their customers and turn a quick profit by touting their patent medicines as, ‘the cure of secret disorders VENEREA VEGETABILIS...pills [that]

Blue Pills: Did Our 16th President Suffer from Mercury Poisoning?’ , *Perspectives in Biology and Medicine*, Vol. 44, No. 3 (Summer 2001), 315-32.

⁵⁰⁵ Porter, *Greatest Benefit to Mankind*, 10.

⁵⁰⁶ As we shall see, this often fatal dose of calomel derived its label ‘10 and 10’ after Benjamin Rush’s heroic therapy used on yellow fever victims. This consisted of ten grains of calomel and ten grains of jalap. Calomel worked as a purge and jalap a laxative.

⁵⁰⁷ Warder Morris, Receipt Book, Sept. 1804, HSP.

⁵⁰⁸ Bynum, *Wages of Sin*, 16,

possess great advantage' or 'Dr. Harvey's Concentrated Sarsaparilla Syrup'.⁵⁰⁹ What riled the abovementioned Southwark quack about the German druggist was that he sold standard medicines and a large range of homeopathic remedies, although the content of these potions remained a secret. He remarked 'I fancy the patient pays for it in the end'.⁵¹⁰ These remedies were more expensive simply because botanic compounds were known for their gentler side-effects, and not because they were more costly for the druggist who could buy ingredients native to their land relatively cheaply.

Temkin explains the binary approach towards venereal treatment most concisely with an illustration of European medicine; with the professional physicians on one side, and quacks and irregular healers on the other.

...the barbers, pox doctors and low surgeons declared mercury an antidote, or specific as we should say, against syphilis and contended it *had* to be used since the diseased would not yield to anything else. The learned physicians on the other hand, whether they used mercury or not, insisted that each case should be considered individually and that only a doctor who could judge the temperament of his patient really knew how to manage the case on a rational basis. For the one the remedy was everything, for the other it was but a good or bad instrument.⁵¹¹

Thus, for the professional doctor observation and controlled dosage was paramount, and almshouse doctors generally adhered to this principle. We naturally associate quackery with dishonesty and foul play and it was indeed an occupation that could bring riches. Yet, this is not to say the majority of quacks were villains who blatantly intended to injure their customers. They simply sought to turn a profit. Mercury treatment required months of confinement which was compounded by chronic lingering after-effects. As Marie McAlister points out, it is little wonder that the diseased turned to alternative medicine supplied by charlatans, hucksters as well as reputable irregulars.⁵¹² So too did a number of Philadelphia almshouse doctors in an effort to provide less aggressive therapy for their patients, a strategy that has been generally overlooked by historians.

⁵⁰⁹ Aug. 1836, 12 May 1837, PPL,

⁵¹⁰ Mitchell, *Autobiography*, 46.

⁵¹¹ Temkin, 'Therapeutic Trends', 315.

⁵¹² McAlister, 'John Burrows and the Vegetable Wards', 85.

In 1786, Philadelphia Almshouse physician Samuel Duffield provided a testimony in the Pennsylvania Gazette in relation to a known-quack Mr. McKee's and his patent remedy 'useful in the cure Cancers, old ulcers &c'. Duffield claimed,

Having by my attendance in the alms-house had the opportunity of observing the application of Mr. McKee's medicines on several persons, I am of the opinion...that they may be very advantageous, especially if applied in the judicious manner he recommends. I have never had the opportunity of seeing the progressive operation of the late Dr. Martin's medicines...yet from information as I have received I am induced to believe that their effects are very similar to the effects produced by the medicines administered in the almshouse by Mr. McKee.⁵¹³

What does this account by a learned and respected member of Philadelphia's medical community tell us? There are two significant points worth bearing in mind. First, those men who held important professional appointments nevertheless crossed the boundaries between regular and irregular medicine.⁵¹⁴ Second, Philadelphia doctors held botanical based medicines in high esteem. For this reason, diseased almshouse women were well placed for medical treatment, perhaps more so than their counterparts in much of Europe.

This chapter has provided a tour of the many outlets providing medical services available to diseased Philadelphia residents. It does appear that some diseased almshouse women exhausted the commercial medical marketplace before turning to public welfare. For instance, in 1796, 45 per cent were first-time admissions in an already highly advanced stage of infection, often demonstrating their familiarity with mercury. Yet this only contributes a partial picture. Numerous women arrived at the almshouse for the first time suffering from minor venereal ailments, and while we could argue that they were seeking food and shelter, the evidence suggests this was not the case. When a woman was admitted it was noted if she sought medical treatment, and those who required general welfare provision were noted accordingly. Therefore, with such a range of medical providers and pills, we are left with the

⁵¹³ 18 Oct. 1786, Pennsylvania Gazette.

⁵¹⁴ Benjamin Rush also came out publicly in support of a quack remedy, Dr. Martin's Cancer Powders. He announced, 'I flatter myself that I shall be excused in giving this detail of a *quack* medicine, when the Society reflect that it was from the inventions and temerity of quacks that physicians have derived some of their most active and useful medicines'. Benjamin Rush, *Transactions of the American Philosophical Society held at Philadelphia*, Vol. II, Sec. XVII, 212.

question of why so many turned up for venereal treatment at the almshouse on one occasion only, displaying relatively mild symptoms, which might suggest this was their first stop in the medical marketplace. Poverty provides one answer. Yet, this does not always hold given that preparations specifically for venereal disease were cheaply available outside the almshouse and its onerous regime. Quacks sought to tap the national market and additionally touted their remedies to appeal to all classes of patient as illustrated by the locations of those who used the various newspapers to market their wares.

More than any other group, prostitutes would have been aware of the potential toxicity of mercury, which would be especially revealing when witnessed on the bodies of their associates when compared to those who were not treated with mercury. Mercury exhibited itself on the body relatively quickly, and prostitutes could not deny the mutilation it could cause. Thus, the damage inflicted on diseased bodies saturated with mercury was visible for all to see. If John Cummings could proclaim Hannah Levy who appeared, ‘rotten [and] without cure...from too much familiarity with mercury’ then surely her friends and accomplices did as well.⁵¹⁵ We need to account for those women who came to the venereal ward displaying mild symptoms and early-stage disease. Simply put, prostitutes were especially aware of the consequences of an unchecked chancre or ulcer. Thus, they sought professional treatment immediately by doctors whose therapies they were familiar with based on what they saw and heard from their associates. Inside the venereal ward of the almshouse infirmary, women were treated with therapy which differed in nature from that provided elsewhere. Despite the fact that nineteenth century hospitals carried all sorts of unhygienic dangers, the almshouse appears to have posed less peril to the syphilitic community than elsewhere in the medical marketplace. There is also no escaping the fact that venereal cures cost significantly more than other medicines. Thus, a trip to the dispensary where they could have their symptoms alleviated (or cured as they believed) for free, or the almshouse where they could use their ingenuity to avoid the fee, would have served some women well. Prostitutes therefore selected the almshouse for several reasons. They were provided with food, alcohol and fuel by the

⁵¹⁵ Hannah Levy, 9 Feb. 1796, Dockets.

Overseers of the Poor, and as will become clearer in the following chapters, a medical regimen that was less harmful and more helpful than most of the alternatives.

This chapter has also highlighted that mercury was dispensed throughout the marketplace as a specific in the cure of venereal infection, and botany was also important to Philadelphians for the amelioration of all kinds of disease. By the turn of the century, the public were growing distrustful of the notion that mercury was the only specific in the cure of venereal disease. We are familiar with the egalitarian currents unleashed by the Revolution in the political realm. James Harvey Young points out that ‘with the rise of the common man in America’ there were few ‘human interests’ left untouched as the early republic matured into the Jacksonian era. Thus, the common man now ‘insisted on democracy in the sick room’.⁵¹⁶

Two decades after Samuel Duffield came out in support of a quack remedy, another almshouse physician followed suit. However, on this occasion he found himself in the public spotlight for championing a dubious patent nostrum. Patients who sought a gentler venereal remedy could purchase Dr. Swaim’s Panacea, as noted above. Swaim’s Panacea was promoted as a concoction made from sarsaparilla syrup, believed by some to be liquid gold in the cure for both the venereal and mercurial diseases. Yet, Swaim’s nostrum carried peril, and contemporaries found the formula was ‘neither effective nor safe’.⁵¹⁷ Almshouse physician Dr. Nathaniel Chapman lauded this remedy, and even offered his own testimonial to add to the many others from ‘satisfied’ customers. Chapman -a former pupil of Benjamin Rush- plays a considerable role in the story of Philadelphia’s diseased almshouse women.

⁵¹⁶ Young, ‘American Medical Quackery’, 579.

⁵¹⁷ Ibid. 589.

Chapter Five:

Reconstructing the Polishing Room: the view from above

In the early 1820s, almshouse physician Professor Nathaniel Chapman M.D. became involved in a ‘quackery imbroglio’, by publicly endorsing a patent nostrum manufactured by William Swaim noted by contemporaries as a ‘prince of charlatans’.⁵¹⁸ *Swaim’s Panacea* emerged as one of the most lucrative patent medicines in the early nineteenth century. Swaim claimed the compounds were essentially a botanical base mixture made from sarsaparilla syrup. In 1823 Chapman announced,

I have seen several cases of very inveterate ulcers...healed by the use of Mr. Swaim’s PANACEA; and I do believe that it will prove an important remedy in scrofulous, venereal and mercurial diseases.⁵¹⁹

However, while Swaim collected his profits several Philadelphia physicians investigated the true nature of the panacea after reports claimed it contained the mercurial element corrosive sublimate. The consequence of the enquiry was a public withdrawal of endorsements by several physicians associated with the Philadelphia Almshouse and the Pennsylvania Hospital. Swaim was accordingly exposed as a medical heretic. According to Richman, the medical team at the Philadelphia Almshouse ‘admitted using sixty-three bottles of the nostrum’. A spokesman for the infirmary would later declare that ‘from January 1825...there has not one drop purchased for the use of the said institution’.⁵²⁰

⁵¹⁸ Irwin Richman, ‘Notes and Documents: The Professor and the Quack’, *Pennsylvania Magazine of History and Biography*, Vol. 91, No. 2, (1967), 199. Chapman acted as resident almshouse physician from 1804 until 1832, and held several important medical positions including the chair of *Materia Medica* at the University of Pennsylvania, editor to the *American Journal of Medical Sciences* from 1820, and president to the Philadelphia Medical Society and the American Philosophical Society. His nineteenth century biographer, ex almshouse doctor Samuel Jackson lamented about Chapman, ‘nature has cast him in a plastic mould’. Hence, historians have surprisingly tended to ignore him. His reputation was clearly great throughout Philadelphia’s medical community, and his beliefs – at times in stark contrast to Rush despite his devotion as a pupil- were keenly followed. According to Jackson, ‘the success of Chapman was an exalted reputation and widespread fame...if the medical theory of Dr. Chapman be compared to that of Boerhaave, Cullen, Brown...or Rush...though it had none of the pretensions or celebrity of those short-lived systems, it possesses from its modest adherence to available facts of observation and nature’. See, Samuel Jackson, ‘Biographical Sketch of Nathaniel Chapman M.D.’, *American Journal of the Medical Sciences*, Vol. 29 (1855), 18-31.

⁵¹⁹ Richman, ‘Professor and the Quack’, 200.

⁵²⁰ *Ibid.* 201. Chapman’s almshouse colleague William Gibson (who held a professorship at the University of Pennsylvania) also testified on behalf of Swaim’s patent medicine, admitting he used it in ‘numerous instances’ In fact, so confident was Gibson, he presented a number of syphilitic patients to

So, how did a respected and learned physician like Nathaniel Chapman become entangled with a quack like Swaim? Simply put, Chapman's actions represent both the fine line between regular and irregular medicine in the period, and the transformation in therapeutic approaches amongst medical men in early nineteenth century Philadelphia. These approaches to medicine also ran against the now-infamous medical dogmas preached by Benjamin Rush. His heavily theorised medical doctrine was based on depletion of morbid matter from the body, by draconian measures of bleeding and purging. These procedures had been introduced by Rush during the 1793 yellow fever epidemic. The medical profession aligned themselves, perhaps unwittingly, into two camps, either for or against Rush's methods.⁵²¹

Importantly, this changing approach amongst the learned medical profession co-existed beside two developing therapeutic trends. These shifts were a consequence of an increasing public wariness of regular doctors, within the context of an egalitarian political culture that had been unleashed by the Revolution. First, as outlined in chapter four, during the late years of the eighteenth century distrust of the profession allowed quacks to thrive in the medical marketplace. The cultivation of various 'hidden' remedies peaked around the second decade of the nineteenth century. Yet, as Young points out, the sale of nostrums had its 'substantial beginnings in the decade following the American Revolution'.⁵²² The success of medical quackery in America was attributable to the public's objection to depletive therapeutics employed by some professional doctors. Some regular physicians responded by making their therapies increasingly milder, while others went further and criticized the underlying basis of the dominant heroic therapies. Second, during the opening years of the nineteenth

his class at the almshouse. He told his students that previous drugs tried out on the patients' ulcers had failed, yet 'Swaim's Panacea had restored them to health'. James Harvey Young, *The Toadstool's Millionaire: A Social History of Patent Medicines in America* (Princeton: Princeton University Press 1961), Chapter 5. According to Young, Swaim himself held a 'quasi-position' at the almshouse.

⁵²¹ Martin S. Pernick, 'Politics, Parties, and Pestilence: Epidemic Yellow Fever in Philadelphia and the Rise of the First Party System', in J. Worth Estes and Billy G. Smith (eds.) *Melancholy Sense of Devastation: the Public Response to the 1793 Yellow Fever Epidemic* (Philadelphia: Science History Publications, 1997), 127.

⁵²² Young, 'American Quackery', 579.

century a sectarian assault on professional medicine emerged, and medical sects such as the Thomsonians were able to recruit an army of followers.⁵²³

The outcry resulting from Chapman's involvement in Swaim's nostrum is illuminating. It shows a willingness of Philadelphia's almshouse doctors to shy away from traditional heroic therapeutics, and it highlights how established physicians were not averse to prescribing patent remedies to their patients. Doctors from the almshouse and Pennsylvania Hospital initially embraced Swaim's nostrum. How does this relate to diseased almshouse woman and venereal therapeutics? Benjamin Rush held a particular view on venereal treatment: 'if you are called to a patient with a boil or ulcer, pour in mercury to drive out the disease by a salivation'.⁵²⁴ Unlike Rush, Nathaniel Chapman spoke the language of other foreign physicians. In particular, the prose of Richard Carmichael struck a chord. The medical doctrines of Chapman and several of his almshouse colleagues differed markedly from those of Rush. This would have profound impact on the medical experiences of diseased pauper women. Richard Carmichael was a physician at Dublin's Lock Hospital, whose methods of treating venereal disease made Chapman into one of 'the most ardent American follower [who] early adopted this'.⁵²⁵ Carmichael's *Essay on Venereal Diseases, and the uses and abuses of mercury in their treatment* is a condemnation of doctors who routinely employed mercury to cure venereal diseases. Chapman was so confident of the accuracy of Carmichael's thesis that he included his own preface to the American edition, contending

⁵²³ According to Warner, irregular sects did not exist in the United States until the 1820s and it was only from 1806 when Samuel Thomson began to market his botanical system of domestic practice that Americans recruited in force. John Harley Warner, 'Medical Sectarianism, Therapeutic Conflict, and the Shaping of Orthodox Professional Identity in Antebellum Medicine in, Roy Porter and William F. Bynum (eds.), *Medical Fringe and Medical Orthodoxy, 1750-1850* (Croom Helm: London, 1987), 234-36. For a more detailed account on the rise of 'irregulars' and sects emerging outside the ranks of the regular profession, see William Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: John Hopkins University Press, 1972), chs. 7-8.

⁵²⁴ Thomas D. Mitchell, 'Notes on the Lectures of Dr. Benjamin Rush, 1809-1811', College of Physicians, Philadelphia, hereafter cited as CPP.

⁵²⁵ Chapman was one of a significant group of Philadelphian doctors who studied abroad. After graduating in Philadelphia, he spent time in Edinburgh and London. During his time in London from 1801, he spent two years as a private pupil to John Abernethy, who, with Carmichael put forward the view that venereal disease did not require the use of mercury to aid a cure. Importantly, Abernethy in particular maintained that 'a large proportion of venereal ulcers were not truly syphilitic'. This stance was vehemently adopted by Chapman, and had consequences for diseased almshouse women. See, Thomas Green, M.D., 'Observations on the Treatment of Syphilis without Mercury', *British Medical Association, Transactions of the Medical and Surgical Association*, Vol. 2, (1834), 244. For a short biography of Chapman see Robert M. Veatch, *Disrupted Dialogue: Medical Ethics and the Collapse of the Physician Humanist* (Oxford: Oxford University Press, 2005), 96-102.

...it is now ten years since the first edition of this work was submitted...the opinion of the profession...has been since that period materially altered, and in place of the belief that no venereal complaint can be cured without mercury, it is now very generally acknowledged that every form of venereal disease may be successfully treated without that remedy.⁵²⁶

The Philadelphian editor stated that,

Among those whose authority greatly contributed to sanction and favour the doctrines of Mr. Carmichael...the name of Professor Chapman stands deservedly conspicuous...of which he was early induced to adopt and publicly inculcate in this city [Philadelphia].⁵²⁷

The editor went beyond a celebration of Carmichael's proposed treatments to a criticism of older therapies, noting that: 'it was formerly the case' even among respected practitioners, for a diseased patient to be 'immediately put under a mercurial course without any regard to the nature or appearance of primary ulcers'. The condemned doctors also believed that if the condition 'became worse',

...not enough mercury had been used. The rubbing, and the pills, the washes and fumigations were consequently increased with diligence, and when all the evils were found to be aggravated, and the miserable patient died or suffered humiliation, his fate was regarded as incontestable proof that he had not received enough mercury into his system.⁵²⁸

It is of no surprise that the writer pointed to Benjamin Rush as one of those guilty of this practice. The narratives left by almshouse doctors such as Nathaniel Chapman are important to our story, because unlike those who followed Rush's example, these men did not blindly mete out a blanket remedy of mercury to women who sought medical treatment at the almshouse infirmary.⁵²⁹ The broader purpose of this chapter is to illustrate, through contemporary public and private discourses, that diseased almshouse women came under the attention of doctors who departed from elements of therapeutic practice most commonly associated with Benjamin Rush. Prostitutes and

⁵²⁶ Richard Carmichael, *Essay on Venereal Diseases, and the Uses and Abuses of Mercury in their Treatment, Second American Edition*, (Judah Dobson: Philadelphia, 1825), Chapman's preface to American edition.

⁵²⁷ Carmichael, *Essay*, xiii.

⁵²⁸ Ibid. Quote by editor, 41.

⁵²⁹ Nathaniel Chapman, 'Dr. Chapman's Notes 1810, Volume 1', CPP.

diseased women appear to have preferred treatment in the almshouse because of the nature of medical care and treatment they received there.

5.1 Eighteenth and Early Nineteenth Century Almshouse Doctors

Doctors were often demonized by contemporary observers and subsequent historians, sometimes fairly, yet often unjustly. Popular images of eighteenth and nineteenth century medical men present a stereotyped view of callous, bloodthirsty men who discarded venereal patients as deserving of punitive treatment. According to this view, doctors freely wielded their scalpels, hacking away at venereal sores. Alternatively, if not by the knife, patients were subjected to as much mercury as the body could -or could not- withstand. Such interpretations are the stuff of nightmares, with doctors' bags and medicine chests filled with the instruments required for draconian bleeding, or purges and emetics required for heroic depletion.⁵³⁰ Such caricatures illustrated by contemporary popular medical prints contribute toward this image. Benjamin Rush's statute as the leading doctor and medical educator in late-eighteenth century America has meant that his penchant for massive blood letting and other drastic depletive measures has helped perpetuate the belief that heroic medicine was popular amongst all American doctors.⁵³¹

Doctors who deviated from Rush's practices were willing to exploit a more varied pharmacopeia, one which was brimming with plants native to their country. This aspect of therapeutics was not as widespread and as significant in Europe, perhaps because of the inflated costs of importing plant-based compounds. However, the implications of these alternative treatments were significant to Philadelphia's diseased almshouse women, for they could obtain a treatment regimen that differed from their counterparts on the other side of the Atlantic.

⁵³⁰ The images of the 'old butchers' in America also stems from the practices of colonial physicians. As Duffy points out, colonial records show instances in newspaper editorial columns where individuals sought help for a minor illness, and were 'promptly purged, bled and blistered to death'. John Duffy, *The Healers: a History of American Medicine* (Urbana: University of Illinois Press, 1979), 52.

⁵³¹ Duffy, *Humours*, 70. Historians suggest that bloodletting was an important insignia to American physicians that confirmed professional identity. Warner argues that bloodletting carried 'cardinal symbolic importance for the medical profession'. John Harley Warner, *The Therapeutic Perspective: Medical Knowledge, Practice and Professional Identity in America, 1820-1885* (Mass: Harvard University Press, 1984), 209. The Porters have done much valuable work to illuminate this area of the history of medicine. Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth Century England* (Stanford: Stanford University Press, 1989) 158-70.



Figure 4: James Gillray, 'Breathing a Vein', 1804. The image represents blood-letting (also known as venisection or phlebotomy) a procedure that was employed as a basic therapeutic from classical times, and remained standard medical practice until the nineteenth century. The medical conviction rested upon the notion that illness was caused by an excess of bad blood, thus, to restore and balance the body's natural humours, blood had to be expelled. Morbid matter would also be expelled via emetics to induce vomiting or cathartics as laxatives. The fountain of blood gushing from the patient's arm highlights how unpleasant the experience could be for the patient. Source: Roy Porter, *Bodies Politic: Disease Death and Doctors in Britain, 1650-1900* (London: Reaktion, 2001)

By investigating the mindset of these medical practitioners, it is possible to build a more realistic image of doctors, in particular, almshouse physicians as well as reconstructing treatment in the polishing room. A particularly illuminating way of finding out what doctors thought and did about venereal diseases is to explore what they taught to their students. Robert Jutte argues that 'early modern hospitals for syphilitics have been completely neglected', with the result that 'historical tradition' dismisses these institutions of medical care as 'therapeutically inefficient and their medical staffs unqualified'.⁵³² Philadelphia's almshouse resident physicians were neither inefficient nor unqualified. They in fact comprised a section of the "new

⁵³² Robert Jutte, 'Syphilis and Confinement: Hospitals in Early Modern Germany', in, Norbert Finzsch and Robert Jutte (eds.), *Institutions of Confinement: Hospitals, Asylums and Prisons in Western Europe and North America, 1500-1950* (Cambridge: Cambridge University Press, 2003), 100.

school” of academically trained men who would become highly esteemed physicians practicing in a city often referred to as the crucible of American medicine.

In the colonial period doctors had trained by apprenticeship, yet with the geographically expanding new republic home to an exploding population needed ever increasing numbers of doctors.⁵³³ The old system of medical schools changed also, and American medicine came to be dominated by doctors with European university training.⁵³⁴ According to Rosner, by 1825 the majority of regular Philadelphia physicians had an M.D. although by this date as many were domestically educated as being trained abroad. By the late eighteenth century a group had emerged from the professionally trained cohort, who together comprised a distinct professional body. Many were Philadelphian physicians who were educated mostly in Edinburgh, but also Leyden, London, Paris and Vienna. These professionals enjoyed a respected position unrivalled elsewhere in America. According to Richard Shyrock, ‘there were of course, individual leaders in other cities who were as promising as those in Philadelphia ... [but] as a group the latter were outstanding by 1760’.⁵³⁵ A contemporary Philadelphia physician could therefore declare that Philadelphia physicians held a ‘world standing second only to Parisians’.⁵³⁶ This group of eminent physicians would carry their teaching and influence into the Philadelphia Almshouse. Amongst those almshouse doctors most pertinent to our period were those from the second generation of Philadelphia medical men who attained foreign degrees. Like their preceptors, most were products of a European education and those who practiced at the almshouse include James Anderson, Nathaniel Chapman, Samuel Duffield, Adam Kuhn, John Redman Coxe and Casper Wister. Also involved are Benjamin

⁵³³ John S. Haller, *American Medicine in Transition, 1840 -1910* (Illinois: University of Illinois Press, 1981), 196.

⁵³⁴ Rosner points out that the graduates of the University of Pennsylvania did not dominate Philadelphia practice. As we have seen, a host of medical practitioners attended to the sick of Philadelphia. For a detailed analysis of Philadelphia physicians and the ‘Edinburgh model’ see, Lisa Rosner, ‘Thistle on the Delaware: Edinburgh Medical Practice, 1800-1825’, *Social History of Medicine*, Vol. 5, No.1 (1992), 19-42.

⁵³⁵ Shyrock, *Medicine and Society*, 21. The literature on this aspect of late eighteenth and early nineteenth century medicine in Philadelphia is vast. See, Haller, *Medicine in Transition*, 196; Duffy, *From Humours*, 31; Whitfield Bell Jr. *The Colonial Physician & Other Essays* (Science History Publications, Philadelphia 1975), 57-70; Francis Packard, *Some Account of the Pennsylvania Hospital from its Rise to the Beginning of the Year 1938* (Philadelphia, 1938).

⁵³⁶ Charles Caldwell and Harriet W. Warner, *Autobiography of Charles Caldwell M.D.* (Philadelphia, 1855; Reprint New York, De Capo Press, 1969).

Rush and his side-kick Charles Caldwell, both of whom practiced at the almshouse, although for very limited periods.⁵³⁷

Unlike the workhouse infirmaries of Europe, a medical training through an appointment at the almshouse was an esteemed position, and historians have shown that some of the country's most distinguished physicians practiced in the almshouse from the eighteenth century on. Rosenberg notes that the Philadelphia Almshouse was 'the largest and to medical students, the most desirable of the municipal hospitals throughout the [nineteenth] century'.⁵³⁸ While some physicians held appointments at both the almshouse infirmary and the Pennsylvania Hospital, the tendency was to be more affiliated with one institution over the other. By the turn of the century, 'there existed, at this time much unamiable temper as well as jealousy' between the governors at each institution', as ex doctor David Hayes Agnew pointed out in the nineteenth century. The consequence of this practice was the passage of a resolution in the early nineteenth century, rendering 'all the physicians and surgeons holding places in the Pennsylvania Hospital ineligible to an election in the almshouse'.⁵³⁹ The almshouse infirmary then was not only the largest municipal hospital in America but also one the most prestigious sites of clinical teaching in the early years of the nineteenth century, also hosting the first lectures to be held on midwifery in America.⁵⁴⁰

⁵³⁷ For biographies on some of the above-mentioned physicians see, David Hayes Agnew 'The Medical History of the Philadelphia Almshouse', in John Welsh Croskey (ed.), *History of Blockley: A History of the Philadelphia General Hospital from its Inception* (Philadelphia, 1929); Hunter, *Origin of the Philadelphia General Hospital*; Lawrence, *History of the Philadelphia Almshouse* (1905); Thomas Morton, *The History of the Pennsylvania Hospital, 1751-1895* (New York: Arno Press, 1973). For the best studies on individual doctors see, Marion E. Brown, 'Adam Kuhn: Eighteenth Century Physician and Teacher', *Journal of the History of Medicine and Allied Sciences*, Vol.5, (1950); Leonard K. Eaton, 'Medicine in Philadelphia and Boston, 1805-1830, *Pennsylvania Magazine of History and Biography*, Vol. 75 (1951). On Casper Wister and John Redman Coxe see Samuel D. Gross, *Lives of Eminent American Physicians and Surgeons of the Nineteenth Century* (Philadelphia: Lyndsay and Blakiston, 1861). For short biographies also see Rothstein, *American Physicians*; Veatch, *Disrupted Dialogue*. See footnote 1 for Chapman's only biographer. The work of American physicians during this era however has been much overshadowed by Benjamin Rush, who is known to us in light of his extreme therapeutic practices.

⁵³⁸ Rosenberg, *Care of Strangers*, 63. Also see Clement who suggests, 'rather than pay doctors to minister to ailing almshouse inmates, welfare officials opened their door to well-established city doctors, who used the institution as a training clinic for their fee paying students...therefore, eminent doctors willingly accepted positions'. Clement, *Welfare and the Poor*, 93.

⁵³⁹ Agnew, 'Medical History', 13.

⁵⁴⁰ Ibid.

The most important physicians connected to the infirmary in the late eighteenth century appear to have been Samuel Duffield and Casper Wister. Wister was appointed in 1788 two years after his return from Edinburgh where he studied under William Cullen. Duffield served as part of the medical team at the same time as Wister, and served for over thirty years as a resident physician to the infirmary. Duffield was also in charge of ‘providing all the drugs needed’, a particularly significant role. Chapman was also a long-serving resident physician, as already noted, beginning his appointment in 1804. Chapman and Duffield do not seem to have had any connection with the Pennsylvania Hospital. Benjamin Rush had little association with the Philadelphia Almshouse, and his only connection was terminated in 1777 when he resigned, after which time he served more permanently in the Pennsylvania Hospital.⁵⁴¹ Rush’s removal may have been a blessing in disguise to diseased almshouse women.

5.2 Contemporary Medical Understanding of Venereal Disease

The extensive historiography of venereal infection essentially plots the progression of the medical understanding of the disease.⁵⁴² The experience of patients receiving treatment remains far less known. We should therefore consider how doctors perceived their patients and their ailments.

What we now understand to be sexually transmitted diseases or simply put, ‘venereal diseases’, contemporaries perceived as various stages of one infection. In short a single venereal disease, with a single cause.⁵⁴³ Today we are aware of a number of sexually transmitted diseases; AIDS, genital herpes, scabies, crabs, chancroid, trichomoniasis, and the two pertinent to this study, gonorrhoea and syphilis.⁵⁴⁴

⁵⁴¹ Ibid.

⁵⁴² The best works setting out the progressive understanding of the pathology of venereal diseases include: Allan Brandt, *A History of Venereal Disease in the United States since 1880* (Oxford: Oxford University Press, 1987); Jay Cassel, *The Secret Plague* (Toronto, University of Toronto Press, 1987.); Thomas P. Lowry, *Venereal Disease and the Lewis and Clark Expedition* (Nebraska: Nebraska University Press, 2004); John Parascandola, *Sex, Sin and Science: A History of Syphilis in America* (Westport: Praeger, 2008); Claude Quétel, *The History of Syphilis*, translated from the French by Judith Braddock and Brian Pike (London: Polity Press, 1990).

⁵⁴³ For a discussion on the way eighteenth century doctors understood the nature of venereal diseases and the implications this has for historians see Siena, *Venereal Disease*, 15.

⁵⁴⁴ Stephen Lock, John M. Last, George Dunea (eds.), *The Oxford Illustrated Companion to Medicine* (Oxford: Oxford University Press, 2001).

Gonorrhoea is contagious, and although it often remains hidden to women in the early stages, it can still be transmitted during this period. If left untreated the site of infection may turn into a large abscess. It can also be disseminated through the bloodstream of the body and affect fluid in joints.⁵⁴⁵ Until recently penicillin effectively treated gonorrhoea, however the increasing use of antibiotics is rendering this useless. Syphilis is caused by a spirochete, which can die quite easily outside of the body. However, if it thrives within the body its symptoms can be numerous. During the primary phase, the first symptom is as a painless chancre (ulcer) which can last a month or so if untreated. The disease may then move into its secondary stage taking the form of lesions, lumps, ulcers, eruptions, rashes and scabs.⁵⁴⁶ Importantly, the symptoms may disappear and not return. A latent phase can also occur, and its effects may even arise after years or decades. Lowry explains that ‘the spirochetes...are busy at work during this phase, torturing the victim with every imaginable symptom’ including, eye inflammation, partial blindness, headaches, deafness and vomiting. Moreover, during this phase, with ‘the initial chancre long forgotten, the patient usually received a catalogue of mistaken diagnoses’.⁵⁴⁷ This makes quantifying the evidence problematic. One-third of cases of untreated syphilis will enter the tertiary phase, which attacks the brain and nervous system.⁵⁴⁸

Although we know gonorrhoea and syphilis are caused by different bacteria and are thus distinct diseases, two hundred years ago the medical profession believed gonorrhoea was an early manifestation of syphilis.⁵⁴⁹ In its most simplistic framework, the disease was linked by a two-stage process. As Siena explains, ‘a clap represented the first stage, when the genital symptoms were characterised by localized sores’.⁵⁵⁰ Thus, the famous Philadelphia physician Philip Syng Physick and his nephew John Syng Dorsey could claim, ‘gonorrhoea and chancre are primary symptoms of venereal disease’.⁵⁵¹ Contemporary doctors claimed they could treat the disease more successfully during this “gonorrhoeal” phase, or the consequences for the patient

⁵⁴⁵ Lowry, *Venereal Disease*, 6.

⁵⁴⁶ *Ibid.* 7-8.

⁵⁴⁷ *Ibid.* 10.

⁵⁴⁸ *Ibid.*

⁵⁴⁹ In 1838, Philippe Riccord separated gonorrhoea from syphilis and from then the medical profession spoke of two distinct sexually transmitted diseases.

⁵⁵⁰ Siena, *Venereal Disease*, 17.

⁵⁵¹ Thomas D. Mitchell, ‘Notes on the Lecture’s of Surgery delivered by Drs. Physick and Dorsey in the University of Pennsylvania’, 1809-1810’, 344.,CCP.

could involve progression to the next stage of the disease, known as the pox or Lues Venerea.⁵⁵²

Delineating how venereal disease was diagnosed and treated in the past is not a straightforward exercise. Despite a common understanding of its most basic features, contemporaries were at odds over the nature of the various stages, to the extent that Chapman himself admitted that, 'the profession at the present are quite unsettled; so much so that probably no two practitioners think alike on the subject, or pursue precisely the same mode of treatment for their cure'.⁵⁵³ By the closing years of the eighteenth century, some medical men were already tentatively suggesting the existence of two separate diseases. Such medical opinions were fiercely resisted: one London doctor scorned 'those authors who consider these as two distinct diseases, and give it as their opinion that they arise not from the same contagious matter'.⁵⁵⁴ Almshouse physician Nathaniel Chapman may well have been one of those scorned, and even from the early years of the nineteenth century the doctor questioned orthodox opinion. Although doctors generally concurred over certain fundamental features of its manifestations, they rarely agreed on how best to treat the symptoms of venereal diseases. During a lecture in 1810 Chapman told his students, 'there has been a great variety of modifications...at present I believe...they are different and demand different treatment'. He was however wary of attacking current medical opinion, 'I have no wish to receive controversy on this subject'.⁵⁵⁵ This begs the question then: was Chapman was already pondering whether or not they were indeed the different diseases that were isolated by the French Riccord in the 1830s? While Chapman's notes and lectures are dated from around 1810, he does state that 'it is five years since I promulgated these views'. He also addresses his opinion that gonorrhoea and

⁵⁵² Siena, *Venereal Disease*, 17.

⁵⁵³ Richard Carmichael, *Uses and Abuses of Mercury*. Chapman's Preface. This confusion can only really be understood within the variances of opinion that surrounded any disease. As Rudolph Kampmeier explains, 'during the first half of the eighteenth century, Boerhaave of Holland had rooted out the traditional humours as causes of disease -blood, phlegm and bile- and replaced them with acidity, alkalinity, tension and relaxation. In disagreement, William Cullen...maintained that an excess or insufficiency of too much tension was the cause of illness'. Rudolph Kampmeier, 'Venereal Disease in the United States Army: 1775-2900', *Journal of Sexually Transmitted Diseases*, Vol. 9, No. 2, (1982), 100.

⁵⁵⁴ George Wallis, M.D., *The Art of Preventing Diseases and Restoring Health* (Robinson, London, 1793), 765.

⁵⁵⁵ Nathaniel Chapman, 'Chapman's Lectures on the Practice of Physic, Vol. 2' [after 1810], CCP

syphilis were entirely different diseases quite explicitly, noting that when he first suggested this [c. 1805], his 'views were deemed altogether heretical'.⁵⁵⁶

More importantly, Chapman was convinced that the majority of infirmary cases were probably of a non-venereal or gonorrhoeal nature. It therefore seems likely that the majority of diseased women were in fact suffering from common ulcers, early gonorrhoeal infections, or soft chancres and indeed mercury poisoning, rather than fully fledged pox. This is an important point to consider when we examine how individual doctors treated each stage of disease.

In 1810, considering historic diagnosis and treatment, Chapman told his students that,

...practitioners were prone to suspect all complaints of the genital organs to be of a venereal nature and the mistake is yet of frequent occurrence...I am convinced that Syphilis is comparatively of rare occurrence and I am confident that most cases are not venerealI do not believe 1/10th or 1/20th of the ulcers I see...are of venereal nature.⁵⁵⁷

The physician therefore seems to have been careful during diagnosis, making an effort to separate the nature and severity of venereal cases. It is also likely he encouraged his almshouse colleagues to follow suit. When Charlotte May was admitted in 1815, it was carefully noted that she was noted by the attending doctor as suffering from gonorrhoea and syphilis.⁵⁵⁸ This point is especially important for the countless women who arrived at the almshouse suffering from ulcers or sores that were recorded as venereal. If treated by Chapman or like-minded attendants, she would have received a meticulous diagnosis, and therapy from a physician who did not wade in with a large prescription of mercury. To this end, almshouse women may have been fortunate to be on the receiving end of medical care that was precise in diagnostics, uncommon

⁵⁵⁶ Nathaniel Chapman, 'Dr. Chapman's Note's Vol. 1, 1810', CPP.

⁵⁵⁷ This was also the language of Carmichael, who claimed 'one of the great errors in practice arises from an inference that all ulcers or pains that are relived by mercury, must therefore be syphilitic, and consequently, that a full course of mercury is required for their cure'. Carmichael, *Uses and Abuses of Mercury*, 217. This makes quantifying the almshouse registers problematic. When a diseased woman turned up at the almshouse she was entered in admission books first by the steward, and only later was she physically examined. Although 'ulcer' cases were as numerous as venereal ones, it does make for confusion and difficulties for the historian attempting to identify those who were venereal. This also hampers accounting for the disease's prevalence in early Philadelphia.

⁵⁵⁸ Charlotte Hay, *Guardians of the Poor, Philadelphia Almshouse Hospital Medical and Surgical Case Notes*, 1816, PCA.

elsewhere in the medical marketplace. Not all doctors resorted to mercury and by the late eighteenth century its efficacy and poisonous effects were increasingly questioned. To the benefit of most almshouse patients, treatment seems to have been essentially based on trial and error judgements: all a doctor could really say or do was whether or not a specific drug had the desired effect through observation of the patient.⁵⁵⁹ This was an empirical take on medicine. However, some doctors (following Rush's example) were more disposed to theory based medicine.

5.3 Eighteenth and Nineteenth Century American Medicine

The contemporary conceptual frameworks that informed understanding of all diseases helps explain why physicians interpreted venereal diseases in such ways. This also illustrates why many physicians perceived multiple venereal diseases as a single-disease. The forms of therapeutics prevalent at the end of the eighteenth and early nineteenth centuries should account for the system of beliefs and behaviours that both physician and layman participated in, Rosenberg points out.⁵⁶⁰ In 1800, the medical profession remained largely ignorant of the structural or bodily changes produced by most diseases, and as Cecil Drinker notes they knew even less on 'the chemical and functional alterations' consequential from illness.⁵⁶¹ Therefore, the doctor was often perplexed during diagnosis because he simply could not comprehend or visualize cause and effect or what was actually happening. The basis of diagnostics mostly rested on ancient Hippocratic theory, which was abandoned in the eighteenth century. The key to this belief system was based upon the notion that illness had no local origin in the body, and thus disease was instigated by an imbalance of the four humours (blood, phlegm, yellow and black bile). Good health was reflected by equilibrium of the body's humours, and illness with disequilibrium. The body's state

⁵⁵⁹ Cassall, *Secret Plague*, 46.

⁵⁶⁰ Charles Rosenberg, 'The Therapeutic Revolution: Medicine, meaning and social change in nineteenth century America', in, Rosenberg, *Explaining Epidemics*, 12. For instance, the public often believed they were being cured simply by the sight of a doctor carrying out extensive blood-letting. This 'ritualised' aspect of medicine was especially important to the wealthier classes. We shall return to this in chapter six.

⁵⁶¹ Cecil Drinker, *A Chronicle of Medicine and Doctors in Colonial Philadelphia* (New York: Oxford University Press, 1937), 43.

also interacted with its environment, which then caused illness.⁵⁶² Rosenberg explains that medical thought rested upon the assumption that every part of the body was ‘related and inextricably linked with each other [thus] a distracted mind could curdle the stomach’.⁵⁶³ Most American physicians in 1800 approached medicine without relying on diagnostic tools beyond their senses and the basic tenet of this model rested upon intake and outgo.⁵⁶⁴

Benjamin Rush established his own belief system in the last decades of the eighteenth century (based on the above theories), which was essentially characterised by ‘rationalist’ medicine. Rush’s therapeutic convictions rested upon a philosophical approach to medicine, supported in its base form by a monolithic system. This approach to medicine was based on symptoms occurring within a framework that conceived the ‘human body as an integrated whole, so that individuals, not organs or body parts, were the actual loci of disease’.⁵⁶⁵ Disease was therefore caused by one underlying condition, which affected the whole constitution. The ‘rationalist’ practice of regarding all illnesses as part of the one disease -that might be manifested in a variety of symptoms- was also supported by a therapeutic conviction emphasising depletion of morbid matter from the body. Rush believed that medicine had been handicapped by an ‘undue reliance upon the powers of nature in curing diseases’, with Hippocrates being the guilty instigator. Rush had little time for Hippocratic medicine, and as he told his students, ‘Hippocrates visited patients, every hour, patted nature on the back...and obtained the name of the Father of Physic’.⁵⁶⁶

Regular physicians who supported ‘rationalist’ medicine tended to promote what historians have termed ‘therapeutic extremism’.⁵⁶⁷ Rush dictated that therapy for a unified system would correspondingly be intrusive and abrasive: ‘desperate measures

⁵⁶² Rosenberg, ‘The Therapeutic Revolution’, 12. According to Kastor and Valencious, ‘few medical authorities would have subscribed to such a simplistic or obvious humoralism, and yet therapeutics of the era was deeply conservative’. Kastor and Valencious, ‘Sacagawea’s Cold’, 298.

⁵⁶³ Ibid. For similar discussions see Duffy, *Healers*, 98; Temkin, ‘Therapeutic Trends’; David Wooton, *Bad Medicine: Doctors doing Harm since Hippocrates* (Oxford: Oxford University Press, 2006)

⁵⁶⁴ Rosenberg, ‘Therapeutic Revolution’, 13 and *Care of Strangers*, 71-73.

⁵⁶⁵ William F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), 16-17.

⁵⁶⁶ Mitchell, ‘Notes on Rush’s Lectures’.

⁵⁶⁷ John Harley Warner, ‘The Fall and Rise of Professional Mystery: Epistemology, Authority and the Emergence of Laboratory Medicine in Nineteenth Century America’, in Andrew Cunningham, Perry Williams, (eds.) *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992), 124.

require desperate remedies'.⁵⁶⁸ Depletion was obligatory through massive bleeding and purging. Phlebotomy would restore the body's blood levels and a strong cathartic or purge would cause the bowels to bleed or make the patient puke. Rush advised his students to 'open every outlet that nature presents'.⁵⁶⁹ His ideas were solidified during Philadelphia's disastrous yellow fever epidemic in the 1793 and his views gained many supporters, which also influenced European opinion of American therapeutics. American doctors were perceived as crude with their therapeutic practices, and were generally viewed as a homogenous group who espoused the doctrines of therapeutic overkill associated with Rush.⁵⁷⁰ Thus, as Duffy contends,

...when confronted with a sick patient, they unhesitatingly gathered their purges and emetics, couched their lancets, and charged the enemy, prepared to bleed, purge, and vomit until the disease was conquered.⁵⁷¹

However, while this image was certainly a fair representation of some, Rush's views did not go unchallenged, and the opinions of those orthodox doctors who opposed him (including almshouse physicians) have been generally obscured.⁵⁷²

5.4 Mercury is King

During the eighteenth and well into the nineteenth centuries, mercury remained the most popular therapeutic employed by a majority of Western doctors for the cure of venereal disease. It was applied in a variety of ways, either as an enema, ointment, pill or vapour, and doctors therefore advocated quite varied treatments. This is most succinctly summed up by the French physician Desruelles, writing in 1817.

Every physician has a peculiar plan of treating...the same disease...Some place entire confidence in the corrosive sublimate, others in mercurial frictions, some recommend

⁵⁶⁸ Rush quote taken from Duffy, *Humours*, 95.

⁵⁶⁹ Mitchell, 'Lectures of Rush', 27.

⁵⁷⁰ This was partly down to the fact that (apart from an elite minority based in Philadelphia) American physicians were by and large either apprentice-trained or had taken degrees from one of the country's medical colleges.

⁵⁷¹ Duffy, *Humours*, 68-71.

⁵⁷² According to Duffy, in 1800 Rush was regarded as the greatest American physician, yet after his death in 1813 his approach to medicine was questioned from many quarters, and by the 1830s he was 'almost universally condemned'. However, the backlash against Rush tended to emphasise the harm done by his debilitating treatment, obscuring his instigation of a public health movement and his work in the field of psychiatry, which were certainly ahead of his time. Yet, as Duffy also points out, we now have a more even-handed image of him. *Ibid.*, 97.

gold; others reject all compound remedies, while others again tire out their patients with them. Opium has many partisans, iodine also.⁵⁷³

The effects of mercury in all its forms could be chronic and painful, particularly when administered orally with tooth decay and ulceration the most common effects, and this was even before it began to poison the rest of the body.⁵⁷⁴ By the nineteenth century some physicians preferred internal administration for its ease of use, whether by pill or injection. The ramifications for a patient who was on an oral regimen of mercury were even worse than external applications where poisoning was less likely, although as we shall see below, frictions could also prove injurious.⁵⁷⁵ External application was a more arduous task whereby mercury ointment was rubbed in daily for several weeks. The full treatment however could last between one to several months with the patient often producing several pints of saliva a day.⁵⁷⁶ According to physician and historian Thomas P. Lowry, ‘doctors, to hurry this process, placed the patient in a steam room for two or three weeks while coating his body with mercury ointment’.⁵⁷⁷ Fumigation was also used although its popularity waxed and waned. The pharmacist would distil quicksilver from heated cinnabar and mix the liquid metal with herbs, which would then be heated over coals. The patient would sit over a skillet completely covered from head to toe all the while inhaling the toxic fumes of mercury vapour.⁵⁷⁸

Salivation was the dangerous procedure following the forceful and aggressive administration of mercury when the patient would produce excessive amounts saliva or sweat, the extent of which was determined by the amount of mercury dispensed. Peter Lewis Allen explains the procedure.

⁵⁷³ H.M.J. Desruelles, *Memoir on the Treatment of Venereal Diseases without Mercury, Employed at the Military Hospital of the Val-de-Grace*, Translated from the French by Guthrie (Philadelphia: Carey & Lea, 1830), 70.

⁵⁷⁴ David Peck, *Or Perish in the Attempt: Wilderness Medicine in the Lewis and Clark Expedition* (Montana: Farcountry Press, 2002), 16.

⁵⁷⁵ In external form the application to the skin resulted in slower absorption of the poison and slower manifestations of side-effects noted Peck. Peck explains that mercurial poisoning is most easily achieved through oral absorption of a mercury salt such as calomel or bichloride of mercury, while ‘application to the skin results in slower, less intense absorption...chronic exposure to elemental mercury (the non-salt form) takes a bit longer to rear its ugly head.’ Ibid., 117.

⁵⁷⁶ Siena, *Venereal Disease*, 22-3, 102.

⁵⁷⁷ Lowry, *Venereal Disease*, 26.

⁵⁷⁸ Deborah Hayden, *Pox: Genius, Madness and the Mysteries of Syphilis* (Basic Books: New York, 2003), 49.

Patients were shut in a “stew”, a small steam room, for twenty or thirty days at a time. Seated or lying down, they were spread from head to foot with a mercury-based ointment, swathed in blankets, and left until the sweat poured down; often they fainted from the heat. Disgusting secretions issued from their mouths and noses; sores filed their throats and tongues; their cheeks and lips, and the roofs of their mouths. Their jaws swelled; often their teeth fell out.⁵⁷⁹

It was widely believed that salivation was the grand finale of mercury treatment signalling that the body was now in a state of expelling the poison responsible for the disease.⁵⁸⁰ Thus, the ‘hotter the room, the sooner they [the patient] would be cured’, and not surprisingly, as Allen notes ‘many patients often died as a consequence of ‘overheating the stew’.⁵⁸¹ The most important aspect of this procedure worth bearing in mind is that the key element needed for a “successful” salivation was external heat or vapour, exemplified in figure 5. In short, salivation was abrasive. Moreover, what doctors often failed to appreciate was that this often resulted in mercury poisoning, which exacerbated symptoms already present on the woman’s body and indeed introduced new complications. Many almshouse women arrived in physical states suggesting they had already been dispensed with large amounts of mercury elsewhere before almshouse incarceration. Mercury poisoning often attacked the mouth first, and evidently diseased women had been using mercury prior to almshouse care. On Mary Franklin’s first admission in 1812, the steward presumed her venereal because she had a ‘sore mouth’.⁵⁸²

⁵⁷⁹ Allen, *Wages of Sin*, 53-54.

⁵⁸⁰ A respected Philadelphia apothecary recommended the best practice for bringing about a salivation: ‘As a general rule to produce salivation, take one or two 1 grain calomel pills night and morning, and rub on the inside of the thigh, about the size of a hazel nut mercurial ointment at night on going to bed; this is to be continued until the gums become tender and there is a free discharge of spittle’. George Burgin M.D., *Directions* (Philadelphia, 1823). Also see Peck, *Or Perish in the Attempt*, 117.

⁵⁸¹ Allen, *Wages of Sin*, 54. For other descriptions of salivation see, Oscar Reiss, *Medicine and the American Revolution*, 159; Robert Jutte, ‘Institutions of Confinement’, 113; Wyke, ‘Hospital Facilities’ 81.

⁵⁸² Mary Franklin, *Weekly Census and Admissions*, 1812.



Figure 5: Steven Blankaart, *Die belagert-und entsetzte* (1710). The scene represented in this image illustrates salivation and fumigation in the treatment of syphilis. Note the presence of external heat in each scenario. Source: Parascandola, *Sex, Sin, Science*, 16.

Unfortunately no detailed narratives of salivation have been left by American doctors. Mary Margaret Stewart has demonstrated how treatment with mercury would be carried to salivation in England. She explains,

standing before a fire, the patient began the cure by rubbing mercurial ointment into her feet and ankles...until absorbed...She then covered up the parts to which she had applied the ointment and got into a warm bed...From the beginning to the end of this

remedy the patient was instructed to keep her chamber warm. During this period of friction, the patient remained wrapped in flannel and spent most of her time in bed.⁵⁸³

The period of friction could last for around twenty days, during which time she would be spitting copious amounts of saliva and sweating profusely. After around three weeks once the patients had sweated and spitted and her ulcers healed, she would be taken out of her confinement, have her 'foul' flannels removed, and put to bed in clean flannels with clean linen. All told, the treatment could last between weeks or even several months until the ulcers healed.⁵⁸⁴ The appearance of healed ulcers was taken as a sign of cure, while the sweating and spitting merely indicated that the therapy was working. The above accounts illustrate just how toxic and gruesome the salivation procedure was, whether it was induced by external or internal dispensations of mercury. Accordingly, some doctors condemned the practice and one London medic suggested that, 'the torments of a salivation should be avoided'.⁵⁸⁵

The question of drug choice and dosage levels is a central theme of this chapter. Some physicians preferred moderation, which 'appeared to aid the body in its normal healing process' while drugs such as antimony, arsenic and iodine were believed to produce an alterative effect.⁵⁸⁶ Yet mercury was perceived as the most potent weapon for bringing about an alterative state because it induced a more severe salivation. The mercury derivative calomel became particularly popular in America, and depending on dosage it was used as a purgative.⁵⁸⁷

This also suited the doctrine of those who followed a therapeutic regimen akin to Rush, and it particularly complemented the humoral theory because salivation or seating would eliminate the body's morbid humours and affect a cure.⁵⁸⁸ Salivation

⁵⁸³ Mary Margaret Stewart, 'And Blight with Plagues the Marriage Hearse', in Merians, *Secret Malady*, 108. The above account by Stewart is a description of therapeutics in the domestic setting carried out by a private physician.

⁵⁸⁴ Ibid.

⁵⁸⁵ Quoted in Linda E. Merians, 'The London Lock Hospital and the Lock Asylum for Women', in Merians, *Secret Malady*, 131.

⁵⁸⁶ An alterative effect was 'altering the fundamental balance of forces and substances which constituted the body's ultimate reality'. If the patient was seen to be in a toxic state, that is, producing copious amounts of sweat and diarrhoea, it was proof the drug was producing the desired effect. Thus, the body's humours would be restored to their normal balance and the body was sufficiently altered back to its normal state. Rosenberg, 'Therapeutic Revolution,' 16.

⁵⁸⁷ Ibid. 17-18. Duffy, *Humors*, 70.

⁵⁸⁸ Temkin, 'Therapeutic Trends', 313.

could also be brought on by other compounds including guaiacum. If this bark was employed the patient would drink a decoction made from the wood, and was then placed in a warm room to sweat out the venereal poison, either wrapped in blankets placed by a warm fire or beside a portable stove. Sometimes mercury treatment was combined with roots such as Guaiacum, Sarsaparilla or Sassafras. In general however, for British doctors especially ‘mercury remained king in the treatment of syphilis until the twentieth century’.⁵⁸⁹

In Philadelphia, just as Europe, medical opinion was divided over the efficacy of mercury. As expected, for Benjamin Rush the greater the dose the better. Rush proclaimed in 1791 that mercury was a ‘safe’ medicine with little alternative to the drug. With singular enthusiasm he exclaimed ‘I believe it does good even where it does not salivate’.⁵⁹⁰ As alluded to, Rush was associated drastic interventionist medicine, and he particularly recommended purges of mercury in the form of calomel, preferably in large and unprecedented dosages. Recall his statement, ‘if you are called with a patient with a boil or ulcer, pour in mercury to drive out the disease by a salivation’. For Rush, not only was mercury *the* cure there was precious little space for a careful diagnosis. He disdained those cautious ‘empirics’ who employed careful doses.⁵⁹¹ Benjamin Smith Barton also followed heroic medicine, and from the lecture notes left by his students it would appear he relied heavily on the use of mercury to treat venereal diseases.⁵⁹² Barton clearly preferred his patients to be salivated as far and as quickly as possible, recommending ‘Quicksilver...to produce a salivation’. Although Barton practised at the almshouse, he appears to have been connected at this institution for one year only between 1804 and 1805. Thereafter, he remained connected to the Pennsylvania Hospital, serving as resident physician from 1798 until 1815.⁵⁹³

⁵⁸⁹ Parascandolala, *Sex, Sin, Science*, 17.

⁵⁹⁰ Benjamin Rush, ‘Observations and Reasoning in Medicine (1791)’, in Dagobert D. Runes, *The Selected Writings of Benjamin Rush* (Philosophical Library: New York 2007).

⁵⁹¹ Mitchell, ‘Lecture Notes of Rush’, 162.

⁵⁹² Barton was professor of materia medica at the University of Pennsylvania.

⁵⁹³ Thomas D. Mitchell, ‘Notes on the Lectures of Dr. Benj. Smith Barton 1809-1810’, CCP. Despite his frequent use of mercury, Barton was especially dedicated to botany and the promotion of vegetable remedies after around 1800 and devoted much of his time developing a vegetable material medica of the United States.

5.5 'The Calomel Brigade': clues from the yellow fever epidemic

There were doctors who found Rush's methods intolerable, and considerable opposition mounted rapidly in the wake of Philadelphia's yellow fever epidemic of 1793. Yellow fever appeared more regularly in Philadelphia than in any other American city, with epidemics occurring throughout the 1790s.⁵⁹⁴ We can use the therapeutic opinions of individual physicians during the 1793 epidemic in order to gauge aspects of medical practice that can be related to venereal treatments. According to Benjamin Rush, 'before I gave mercury in 1793 I did not know it had ever been given before to induce a salivation'.⁵⁹⁵ From that year on, Rush went on a frenzied mission bleeding and purging his patients with calomel.⁵⁹⁶ The battle of the physicians that emerged in response to Rush's methods during the epidemic provides further clues about almshouse medical practices.

Rush's now infamous prescription was commonly known as the 10 and 10, which consisted of a drastic remedy of ten grains of calomel mixed with ten grains of jalap.⁵⁹⁷ Rush found his inspiration for this dosage from Dr. Thomas Young, who purged sick soldiers belonging to the Continental army. Dr. Young's 10 and 10 was the strongest purge Rush had witnessed, yet in the face of an epidemic he dared to employ it uniformly amongst his patients. It was as, Powell notes, a dose 'far stronger than medical men thought safe'; Adam Kuhn called it a 'Murderous dose' and even Barton who favoured the employment of mercury, called it a 'dose for a horse'.⁵⁹⁸

⁵⁹⁴ 'Randolph Klein, 'The Men of 68: Graduates of America's First Medical School', in Randolph S. Klein (ed.), *Science and Society in Early American, Essays in Honor of Whitfield J. Bell, Jnr.* (Philadelphia: American Philosophical Society, 1986), 142.

⁵⁹⁵ Mitchell, 'Lecture Notes of Rush'.

⁵⁹⁶ According to Kopperman, 'the method adopted by Rush in 1793 marked a radical departure from common practice'. Although it was partly a continuum of traditional humoral practice of evacuating morbid humours, it was the extent of rapid depletion that was innovative. Paul E. Kopperman, 'Venerate the Lancet: Benjamin Rush's Yellow Fever Therapy in Context', *Bulletin of the History of Medicine*, Vol. 78, No.3 (2004), 541.

⁵⁹⁷ The British Pharmacopoeia gives the maximum dosage of calomel as 5 grains. Edmund White and John Humphrey, *Pharmacopoeia*, (London: Henry Kimton, 1904), 231-233; Ellis's *Medical Formulary* states (1820s edition) 'the use of calomel in minute doses has become very general'.

⁵⁹⁸ According to Rothstein, one initial dose of '10 and 10' brought on an instant salivation. Rothstein, *American Physicians*, 50. In one patient alone, Rush meted out 80 grains of calomel and 120 of jalap, which, surprisingly did not kill the patient. Powell, *Bring out your Dead*, 82-3, 78-9. The 10 and 10 was supported by the rationalist take on medicine. This set apart the medical profession from those who were influenced by French empirical clinical medicine and those more observant and sceptical of depletive medicine. Duffy, *Humours*, 105.

In the wake of the 1793 epidemic, two conflicting schools of thought and practice emerged. The first, which historians have labelled the ‘Republican Cure’, was supported by the drastic bleeding and purging characteristic of Benjamin Rush and his followers, especially Charles Caldwell. Pitted against them were the ‘cinchona bark and wine’ physicians, who trumpeted the ‘Federalist Cure’.⁵⁹⁹ This was supported most notably by Adam Kuhn and those who deemed the effects of Rush’s remedies as bad as the fever itself. Kuhn proposed a gentler regimen, which included mild purges only if they were needed.⁶⁰⁰ If the patient felt sick, then Kuhn would dispense camomile tea or ‘vitriol, the bark or laudanum...in carefully contrived combination’.⁶⁰¹ The conflict between Adam Kuhn and Benjamin Rush during the yellow fever epidemic is well known, especially because the differences of opinion often materialised in quite bitter terms. The physician Charles Caldwell, a staunch supporter and companion of Rush hated Adam Kuhn, and condemned the latter’s empirical approach to medicine. According to Powell, Kuhn was ‘a careful observer and more original in theory than most [and] refused to be dominated by any general hypotheses’.⁶⁰² Caldwell was more closely associated with the Pennsylvania Hospital, particularly after he was ‘dropped’ by the almshouse managers following a dispute with a fellow physician.⁶⁰³

Adam Kuhn attracted his own followers, including Samuel Duffield and Casper Wister. Wister’s language shows that he was inspired by Kuhn, and his *Commonplace Book* was filled with expressions such as ‘Dr. Kuhn says’ or ‘I informed Dr. Kuhn who was of the same sentiment’.⁶⁰⁴ Wister echoed Kuhn by vehemently and publicly

⁵⁹⁹ Medical opinion on yellow fever therapeutics emerged in the political sphere. See the essays in Estes and Smith, *Melancholy Sense of Devastation*, especially those by Jacqueline Miller and Martin S. Pernick. This dichotomised version is a somewhat crude and simplistic way of approaching the evidence and as Pernick reminds us, ‘politics fails to explain’ the treatment as a ‘stark choice’ that is, ‘heroic doses of bleeding and purging versus supportive doses of cinchona bark and wine...Bleeding and bark were hardly the only remedies available, nor were they mutually exclusive.’ Thus, ‘the therapeutic reality was much more complex and eclectic’. ‘Politics, Parties and Pestilence: Epidemic ‘Yellow Fever in Philadelphia and the Rise of the First-Party System’, in, Estes and Smith, *Melancholy Sense of Devastation*, 137. Also see, Mark A. Smith, ‘Andrew Brown’s Earnest Endeavour: the Federal Gazette’s Role in Philadelphia’s Yellow Fever Epidemic’, *The Pennsylvania Magazine of History and Biography*, Vol. 120, No. 4 (1996).

⁶⁰⁰ Kuhn was an ardent follower of the English physician Thomas Sydenham (the English Hippocrates) who emphasised bedside observation and limited drug intake.

⁶⁰¹ Powell, *Bring Out Your Dead*, 73.

⁶⁰² Ibid.

⁶⁰³ Caldwell was accused of ‘fiddling’ the accounts and was deemed ‘not fit to be retained on the staff’. Lawrence, *History of the Philadelphia Almshouse*, 46.

⁶⁰⁴ Casper Wister, *Medical Commonplace Book 1797-1813*, APS.

opposing Rush's methods. Wister particularly disliked drastic purging and bloodletting, regularly criticizing the army of blood-letters loose in the city. During the yellow fever epidemic of 1797 he remarked, 'I have heard of several deaths in which the bleedings were very copious indeed'.⁶⁰⁵

Samuel Duffield's views are also informative in light of his close involvement with the almshouse. Duffield found Rush's drastic cure obnoxious to say the least. Duffield himself came down with the fever during the 1793 epidemic, and insisted that Kuhn's milder treatments should be employed. This was in opposition even to his own brother Dr. Benjamin Duffield, who adopted mercury and bleeding, albeit not as drastically as Rush.⁶⁰⁶ A further bark and wine supporter was James Hutchinson, the port physician for Philadelphia and outdoor physician for the Overseers of the Poor.⁶⁰⁷ The treatment administered in Philadelphia's quarantine port hospital is illustrative. After Hutchinson's untimely death from yellow fever, Samuel Duffield replaced him, and although he remained committed to his patients at the almshouse, Duffield 'went about his duties with vigour' at the quarantine hospital. Continuing Hutchinson's gentler bark and wine remedies, Benjamin Rush remarked of Duffield: 'the two [port hospital] physicians, Dr Harris and Dr. Duffield are confined....the latter uses Dr. Kuhn's remedies'.⁶⁰⁸ Therefore those physicians most closely aligned with the almshouse were more willing to embrace gentler therapeutic methods, even before the close of the eighteenth century.

Calomel continued to be favoured by some American doctors well into the nineteenth century. Like his predecessors Kuhn and Duffield, Chapman refused to accept the widely held theories on the draconian use of calomel. Moreover, there were certainly regional differences in attitude towards depletive or non-depletive therapy. Southern physicians in particular seem to have had a penchant for using calomel on their patients.⁶⁰⁹ For Dr. Chapman, calomel was simply the enemy, as were the Creole physicians who endorsed its use. He told his students,

⁶⁰⁵ Ibid., 22 Sep. 1797.

⁶⁰⁶ Benjamin Duffield later renounced this method. Powell, *Bring out your Dead*, 209.

⁶⁰⁷ Duffy, *Healers*, 96.

⁶⁰⁸ Klein, 'The Men of 68', 142-3.

⁶⁰⁹ Duffy, *Healers*, 100. There seems to have been a sharp division of medical opinion in the south. Those who characterised Creole culture in Louisiana were split into two camps (similar to the yellow fever doctors) for and against the use of calomel.

Gentlemen, if you could only see what I almost see daily...in this city, persons from the south...emaciated to a skeleton, with both tables of the skull almost completely perforated in many cases, the nose half gone with rotten jaws, ulcerated throats...and a disgusting spectacle to others, you would exclaim as I often have done, “Oh, the lamentable want of science that dictates abuse of that noxious drug calomel in the Southern States!”⁶¹⁰

Calomel began losing credibility by the medical profession at large from the early nineteenth century. According to Kampmeier, the years 1815 until 1818 were marked by ‘retrospective evaluation’ by army medical departments in response to the use of mercury in two wars, the Revolution and Napoleonic Wars.⁶¹¹ Thus, as Duffy notes,

...medical practice among the more able physicians swung away from the policy of active interference to one of caution and moderation. Bloodletting was definitely on the wane, and calomel was beginning to lose its role as the mainstay of medication.⁶¹²

The yellow fever epidemics and the rival treatments that emerged amongst Philadelphia’s medical community therefore illustrates the growing divide over the use of mercury. Although the practice of bloodletting and purging by emetics was a traditional one endorsed by most practitioners, drastic and rapid depletion was an innovation.⁶¹³ Rush took this practice to an extreme and found an army of supporters for his therapies. However, one of the greatest strongholds of opponents to Rush’s therapies was the Philadelphia almshouse, which had huge implications for patients confined in the infirmary. Almshouse physician Nathaniel Chapman for example, complained that ‘he who resigns the fate of his patient to calomel is a vile enemy to the sick’.⁶¹⁴

⁶¹⁰ Daniel Drake and Lusford Pitts Yandell, ‘Abuse of Calomel by Southern Physicians’, *The Western Journal of Medicine and Surgery*, Vol. 6 (1842), 475.

⁶¹¹ Kampmeier, ‘Venereal Disease’, 102

⁶¹² Duffy, *Humours*, 73

⁶¹³ Kopperman, ‘Venerate the Lancet’, 542.

⁶¹⁴ Chapman quote taken from, Erastus Edgerton Marcy, *The Homeopathic theory and Practice of Medicine*, Vol. 1 (New York: William Raddie, 1868), 95.

5.6 Grumbings from the Almshouse

American medical historians point to the period around 1800 in America as being ‘a time of fractious disagreement’.⁶¹⁵ A response to eighteenth century rationalist theoretical excesses emerged in what Warner terms the ‘reorganization of knowledge’ and ‘reorientation from rationalism to empiricism’. In the early years of the nineteenth century, ‘it was becoming evident to many perceptive physicians that neither prevailing humoural medical theories nor traditional forms of therapy were of much value’.⁶¹⁶ According to Temkin, theory was responsible for therapy, thus, theory and medicine changed together around the turn of the century, which made an impact upon Philadelphia doctors, and in turn, diseased almshouse women⁶¹⁷ American doctors developed their own medical identities drawing inspiration from a mix of French and Scottish medical thought. There was change in the air, and new practices developed in the almshouse.

Change was helped by the fact that not all men followed Rush’s “one disease” or “unity of disease” philosophy. During the later eighteenth and the nineteenth centuries, humoural pathology was slowly replaced with a gentler solidist approach, which ‘located diseases in organs, tissues and finally, cells’.⁶¹⁸ While the earlier rationalist approach to healing had placed greater value on the one-disease approach, solidist physicians concerned themselves with local models of disease causation, with more emphasis placed on individual organs, which correspondingly needed specific treatments.⁶¹⁹

Physicians like Chapman and Kuhn drew upon solidist thinking, supporting a gentler therapeutic regimen with the use of mild stimulants.⁶²⁰ As we have seen, Rush found

⁶¹⁵ Kaster and Valencius, ‘Sacagawea’s Cold’, 297. Rosenberg has pointed to this period as being the ‘therapeutic revolution’. Until 1800 he explains, medicine had remained static. Rosenberg, ‘Therapeutic Revolution’.

⁶¹⁶ Duffy, *Humors*, 71.

⁶¹⁷ Temkin, ‘Therapeutic Trends’, 314.

⁶¹⁸ *Ibid.* 315.

⁶¹⁹ Rosenberg, ‘Therapeutic Revolution’, 13

⁶²⁰ Jackson, ‘Biographical Sketch’, 26. Kuhn is most notably known for his opposition to Rush’s heroic medical practices during the yellow fever epidemic, outlined above. According to Warner, in Boston, the therapeutic teachings of local physician James Jackson, Sr., advocated moderation and “respect for nature” and became popular throughout New England. However, Warner claims Bostonian European trained students differed from Philadelphia’s, because in the latter’s case, Edinburgh had been the

his opportunity in 1793 to formulate and reinforce his arguments, encouraging much debate. As Kopperman notes, by the 1790s Rush was an ‘unabashed theorizer, taking a strong position in the debate between rationalists and empiricists’.⁶²¹ Initially influenced by Edinburgh’s William Cullen, from the late eighteenth century this debate coincided with a revival of the Hippocratic empiricist teachings of the classical world.⁶²² In short, theoretical medicine was being shunned in favour of clinical observation, experience and post-mortem dissection.

In the late-eighteenth century Philadelphia’s doctors began to turn their attentions from Edinburgh to France, especially Parisian hospitals where doctors declared that specifics of disease required specific remedies. While these shifts in medical practice should not be exaggerated warns Porter, they were, he states, ‘momentous’ and reached far beyond France.⁶²³ French medicine was widely known and popular in Philadelphia’s early republic. In 1785 Joseph Goss could boast in the *Pennsylvania Packet* that he was a ‘regular bred French physician living in Fourth Street, between Walnut Street and Willings Alley, having had his tuition in Paris and Montpellier’. If patients made their way to Goss’s premises the doctor proposed he would ‘treat ulcers of all kinds...and various maladies which to some might appear incurable’. The Frenchman Moreau de St. Mery opened a book store selling medical wares in the 1790s, and Louis Colin arrived from St. Domingo claiming to have ‘practised Surgery at Paris’ for nine years ‘in one of the greatest hospitals in that City’. Upon his arrival, the doctor placed an announcement a local newspaper to the ‘Gentleman Physicians and Surgeons of this City’. He was desirous to mix with the Philadelphia medical community to ‘furnish Matter for Conversation in English’. The majority of the first and even second generation of university and hospital trained doctors may not have travelled to France, yet they were able to forge vital links with those who had studied

teaching city of choice where theory-based teaching prevailed. However, the gulf does not seem as wide as Warner claims, as many Philadelphian physicians placed the value of experience over theory. Warner, *Therapeutic Perspective*, 23.

⁶²¹ Kopperman, ‘Venerate the Lancet’, 549.

⁶²² According to Whitfield Bell, Cullen had a ‘stupendous’ influence upon the Philadelphia medical community (even Rush in his early days). Adam Kuhn was even accused by Rush’s ‘side kick’ Charles Caldwell of giving lectures that were a ‘mere paraphrase of Cullen’. Bell, *Colonial Physician*, 53-4.

⁶²³ In Philadelphia there had been a significant French presence from Revolutionary period. New ideas resulted from the culmination of the convergence of surgical and medical training, as well as a revival of earlier solidist thinking inspired by Thomas Sydenham in the seventeenth century. As Porter notes, students who were ‘instructed and inspired...returned to Philadelphia to beat the drum of French Medicine’. Porter, *Benefit of Mankind*, 306-7, 315.

in Montpellier and Paris.⁶²⁴

Even in Edinburgh, Cullen taught medicine by a classification approach, arguing that all diseases should be treated separately with specific cures.⁶²⁵ Nosology was a more practical than theory driven approach to medicine, and thus not as restrictive as the single disease theory. Curing diseases could only be brought about by distinguishing local causation. No surprise that Rush discarded Cullen's nosology -despite being his pupil while in Edinburgh- because his theories had little place to incorporate localised disease needing specific. Moreover, for Rush, there should only be a limited number of medicines. Some of his students may have listened in disbelief as he claimed 'our service has been much injured by Cullen'. He declared, 'there are no such things as specific medicines...the doctrine conflicts with the unity of disease'. During the same lecture Rush disdainfully proclaimed of the Philadelphia medical community, 'nosology retains a standing army among some physicians'.⁶²⁶ Importantly, the almshouse was guarded by this 'standing army' and one of its leading generals was Nathaniel Chapman.

Physicians like Kuhn, and later Chapmen drew upon solidist thinking, but modified it by supporting gentler therapeutic regimens with the use of mild stimulants.⁶²⁷ Chapman was especially influenced by the work of John Brown, who perceived the body in quite simplistic terms: imbalances to the humours were caused by either local or constitutional symptoms.⁶²⁸ When describing venereal disease, Chapman frequently referred to its symptoms and stages in either local or constitutional terms, thus each stage required a specific remedy.⁶²⁹ Such medical thought had little room for one-disease theories. Like his predecessor Adam Kuhn, Chapman was 'decidedly sceptical of the truth and medical doctrines of the time' and did not support the

⁶²⁴ 19 Aug. 1785, *The Pennsylvania Packet and Daily Advertiser*; Roberts, *American Journey*.

⁶²⁵ William Cullen was an ardent supporter of the systemization approach, which aimed to classify all diseases, and, although Rush had been greatly influenced by Cullen under his tutorage in Edinburgh, ironically he became one of Cullen's fiercest opponents in the debate over nosology.

⁶²⁶ Mitchell, *Lectures of Rush*.

⁶²⁷ Jackson, 'Biographical Sketch', 26.

⁶²⁸ For a discussion of John Brown's influence on early American doctors, see, Peck, *Or Perish in the Attempt*, 315-19

⁶²⁹ An ex-almshouse physician said of Chapman, 'the doctor set forth in beautiful style and language' the variety of lists of diseases and their different varieties requiring specific treatments. Lewis P. Bush, *Reminiscences of the Philadelphia Hospital and remarks on old-time doctors and medicine* in, Agnew, *History and Reminiscences of the Philadelphia Almshouse*, 72.

depletive theories of the day. This was evident from his practise in the almshouse, where his methods influenced so many almshouse doctors that they became the ‘revived practice of the establishment, with mercury used only in small doses’.⁶³⁰ Almshouse cases of fever are illustrative of Chapman’s views on heroic doses of drugs, and unlike Rush’s supporters in the yellow fever epidemics, Chapman encouraged a ‘mild and partially expectant treatment, iced drinks, teas and dilutants’.⁶³¹

This change in pathology coincided with developments in the medical treatment of venereal disease with the promotion of milder drugs. From the mid-eighteenth century, new theories emerged from France, where doctors advanced a therapeutic system defined by treatment involving limited or no mercury, simply known as the ‘Montpellier Method’. This was most notably developed amongst physicians from Montpellier, where, as Sinena notes, they ‘devised a system of mercurial rubs that did not raise a salivation, which they trumpeted as a safer alternative’.⁶³² Glasgow physician William Mackenzie recorded his thoughts during his travels through France. He observed in his diary that French doctors favoured ‘a pill formed one half of the common mercurial ointment’, and the astounded doctor noted ‘I do not know if they use friction at all in this hospital’.⁶³³ Conversely, the British were far more reliant on the use of mercury than the French, as Wyke points out.⁶³⁴ Thus, French doctors perceived the dangerous procedure of mercurial frictions and salivation to be a distinctly English practice. It would seem that some Philadelphia doctors concurred with them. Chapman condemned those practitioners who ‘had been taught to believe

⁶³⁰ Jackson, ‘Biographical Sketch of Chapman’, 17

⁶³¹ Ibid. 14, 673. According to Jackson, Chapman was a most uncompromising...vitalist, and by the 1820s, his views on general medical theory were in accordance of a large number of the medical profession, which he held from the late eighteenth century’ A vitalist explains Elizabeth Williams, ‘relied firmly on the Hippocratic model of medicine, arguing that close clinical attention to individual patients and maladies was the only proper to medicine’. Elizabeth Ann Williams, *A Cultural History of Medical Vitalism at Montpellier*, (Aldershot: Ashgate Publishing Ltd, 2003), 215

⁶³² Sienna, *Venereal Disease*, 42, Also see Philip K. Wilson, ‘Exposing the Secret Disease: Recognizing and Treating Venereal Syphilis in Daniel Turner’s London’, in Merians, *Secret Malady*, 68-84.

⁶³³ William Mackenzie M.D., *Diary of a Tour and Residence in France, Switzerland, Italy, Austria, Prussia and Germany, 1816-1818*, Royal College of Surgeons and Physicians, Glasgow, 6 June, 1816.

⁶³⁴ Tyke, ‘Hospital Facilities’, 81.

that the slightest ulceration or abrasion upon the genitals called for the routine of salivation'.⁶³⁵

The humoral theory had encouraged therapeutics that eliminated morbid humours through salivation or sweating, and thus restored wellbeing. Now this was challenged by a dualist explanation. The unitary position on syphilis and gonorrhoea interpreted the diseases as the result of a single cause.⁶³⁶ The main issue dividing practitioners who adopted the unitary view in America, was over types of medicinal preparations, mod of employment (frictions, pills or fumigation) and how best to manage side-effects⁶³⁷. On the other side was the dualist argument, based on physiological considerations seeking to detect local manifestations of disease. This had more comprehension between different organs and regions of the body, which explained how a local irritation could become general. An important aspect of this more empirical argument suggested that many symptoms of syphilis could be cured with limited or no mercury, and an overall gentler Galenic approach, with the advocacy of milder remedies. As Rosenberg explains, small doses acted as an agent to gently aid the body in its normal healing process, yet mercury dispensed in large doses could be perceived as 'forceful intervention'.⁶³⁸

Mother Nature also assumed a large role in this new way of thinking, and the crux of the argument was that nature, not the physician cured the patient. The objective of this way of thinking 'accepted nature as a powerful healthy force, so that the physician only needed to be guided by, and help her'.⁶³⁹ This ran against Rush, who taught, 'always treat nature like you would a noisy cat or dog in the sick room; turn them out of the chamber and shut the door'.⁶⁴⁰ Haller claims that,

⁶³⁵ As we have seen, Chapman championed the work of Dublin physician Richard Carmichael.

According to Porter, Irish medicine also fell under the French spell. Porter, *Benefit of Mankind*, 319.

⁶³⁶ Alex Dracoby, 'Theoretical Change and Therapeutic Innovation in the Treatment of Syphilis in Mid-Nineteenth Century France', *Journal of the History of Medicine and Allied Sciences*, Vol. 59, No. 4 (2004), 528

⁶³⁷ Ibid.

⁶³⁸ Rosenberg, 'Therapeutic Revolution', 17.

⁶³⁹ Roy Porter, *Medicine in the Enlightenment* (Amsterdam: Ropopi, 1995), 275.

⁶⁴⁰ Mitchell, 'Lecture Notes of Rush'.

...the suggestion by such men as Nathaniel Chapman...of *vis medicatrix naturae* imparted an unsettling if not outright threatening challenge to the practitioner's identity in the nineteenth century.⁶⁴¹

Chapman valued the Hippocratic healing power of nature, and like him, those who espoused this doctrine had a tendency to come from the northeast.⁶⁴² For these doctors, treatment was more of a "wait and see if nature calls" attitude. Importantly though, the physician was not totally redundant and he did have a role to perform, which was to supervise the self-healing process

While some Philadelphia doctors were convinced by Rush's methods, the late eighteenth century marks the beginning of a transitional period in therapeutic approaches. As Duffy suggests of late-eighteenth century Philadelphia medicine, 'change was already in the air.'⁶⁴³ Diseased almshouse women must have benefitted from the less interventionist practices followed by almshouse physicians. These doctors' approaches were encouraged and influenced by European pathology, along with the institution's financial constraints.

5.7 Almshouse Therapeutics and Venereal Disease

We can learn a great deal about medical procedures carried out in the almshouse venereal ward by examining the lectures and personal papers of individual doctors. As outlined above, the turn of the century represented a transitional period in Philadelphia medicine, and mercury began losing favour amongst some corners of the city's medical profession.⁶⁴⁴ This is perfectly demonstrated by the notes taken by the students who attended the lectures of doctors such as Nathaniel Chapman, John

⁶⁴¹ Both Haller and Warner have shown that the regular medical profession used blood-letting and calomel purging to symbolise their professional identity as opposed to irregular, quacks and botanical doctors. See, Haller, *Medicine in Transition* 29; Warner, *Therapeutic Perspective*, ch. 1. Chapman's writings contradict these statements to a degree. Bloodletting it is argued was employed to draw the lines between orthodox and irregular, and thus it was a tool that set them apart with a distinct professional identity. However, the evidence confirms Chapman as a firm anti-depletive for the most part. Although he did favour bloodletting, he did so on moderate terms.

⁶⁴² Rothstein, *American Physicians*, 43; John S. Haller, *Medical Protestants: The Eclectics in American Medicine* (Carbondale, Southern Illinois University Press, 1994), 29. As noted, those from the south and west were more likely to support abrasive therapy, preferably with the use of calomel as a purgative.

⁶⁴³ Ibid. 73.

⁶⁴⁴ Warner dates this transitional period to a later date in Boston.

Redman Coxe, Adam Kuhn, Casper Wister, and the uncle and nephew team John Syng Dorsey and Philip Syng Physick.

Adam Kuhn

We have seen the prominent role Adam Kuhn played in the yellow fever epidemic as an opponent of Rush's therapy, yet unfortunately lecture notes taken by his students are scarce. Kuhn was a significant influence over Philadelphia's medical community in the late eighteenth century, and served as one of the resident prescribing physicians at the almshouse from 1774.⁶⁴⁵ Chapman, who succeeded him in this role, attended Kuhn's lectures as a student. Chapman was also a student of Rush, and historians have incorrectly assumed that he adopted Rush's methods, when in fact he rejected many in favour of Kuhn's.⁶⁴⁶ Thus, as Irwin Richman suggests, although Chapman was a 'pupil of Benjamin Rush he was a disciple of Kuhn'.⁶⁴⁷ In his personal medical notes on the different stages of venereal infection, Chapman recalls 'the late Dr. Kuhn of this City treated it [gonorrhoea] exclusively with opium...he gave a grain morning noon and evening of the effect of this plan'.⁶⁴⁸ It was common in the eighteenth century to combine caustics with opium, so that the latter would alleviate the pain of the former.⁶⁴⁹ Kuhn was a staunch supporter of the use of opium to treat a host of ills. Inspired by Kuhn, Chapman therefore proposed that 'the free use of opium is never to be overlooked in the cure of Gonorrhoea...its effects are always beneficial'.⁶⁵⁰

John Redman Coxe

⁶⁴⁵ Kuhn was elected twice to the medical staff at the Pennsylvania Hospital (1774 to 1781 and 1782 to 1798) and worked as a consultant surgeon for the Philadelphia Dispensary. Although he accepted the general humoral theories of the day, he made some modifications, particularly regarding therapeutics and drug dosage. Marion E. Brown, 'Adam Kuhn: Eighteenth Century Physician and Teacher', *Journal of the History of Medicine and Allied Sciences*, Vol.5, (Spring, 1950).

⁶⁴⁶ According to Irwin Richman, historians 'overlook the fact that Nathaniel Chapman, who held the prestigious chair of the theory and practice of medicine at the University of Pennsylvania, broke away from many of Rush's dictums...such information is generally unavailable in the secondary works'. Irwin Richman, 'Book Reviews', *Pennsylvania Magazine of History and Biography*, Vol. 88, No. 4, (Oct., 1964), 507.

⁶⁴⁷ Ibid.

⁶⁴⁸ Nathaniel Chapman, 'Dr. Chapman's Notes (1810-1830)', CPP.

⁶⁴⁹ Andreas-Holger Maehle, 'Pharmacological Experimentation in the Eighteenth Century', in eds., Roy Porter and Mikulas Teich, *Drugs and Narcotics in History* (Cambridge: Cambridge University Press, 1993), 64.

⁶⁵⁰ Chapman, Notes.

Professor of chemistry and author of the *American Dispensatory*, John Redman Coxe is also pertinent to this story.⁶⁵¹ Coxe practiced at the almshouse infirmary throughout the 1790s, and was instrumental in rehabilitating Hippocratic practice at the turn of the nineteenth century, as influenced by the French school.⁶⁵² The overall impression of almshouse medicine gained from a study of Coxe's lectures is that plant-based remedies came first. Moreover, when calomel was resorted to, it was dispensed in small doses. Thus, for a case of scrofula Coxe told his students, 'purges should be continued every 3 or 4 days...the best of which is Peruvian Bark'. If the disease continued unabated, Coxe advised that 'mercury must only be insinuated into the system by minute doses... ½ grain calomel 3 times a day'. Such moderation was a far cry from the heroic doses of mercury so characteristic of Benjamin Rush. Instead, Coxe relied heavily on botanical compounds, suggesting that for stubborn ulcers, 'Guaiacum, Sarsaparilla & Saasafra alone or united with Lisbon diet drink' and 'to the ulcer the simplest ointments should be selected'.⁶⁵³ During a lecture on syphilis given at the almshouse, on Coxe told his students, 'a decoction of guaiacum will often suspend the progress of Sec [ondary] Syphilis'. Coxe was adamant that 'mercury is not the only remedy ... blue vitriol (copper sulphate) acts in the same way'.⁶⁵⁴ Coxe was especially opposed to mercurial salivation, telling his students 'disagreeable sores are produced by mercury...[thus] the influence of mercury is very extensive over the whole body'.⁶⁵⁵ He also indicated that if mercury had to be prescribed, 'the best preparation' was 'corrosive sublimate' because 'it is the least apt to salivate'.⁶⁵⁶ Coxe was particularly swayed by the healing power of nature itself: 'even the passions of the mind have produced great changes!'⁶⁵⁷

⁶⁵¹ His grandfather, the eminent physician John Redman (an associate of the young Rush) also followed a milder therapeutic regimen as was revealed in the yellow fever epidemics of 1762 and 1793. Bell, *Colonial Physician*, 31.

⁶⁵² Robert M. Veatch, *Disrupted Dialogue*, 102.

⁶⁵³ Abraham Bitner, 'Note's taken from the Philadelphia Almshouse', Vol. 1, CCP. It should be noted however that each doctor had his specific remedy, and some doctors still employed mercury. Thus, in a severe case of erysipelas in a forty-three year old man, the unnamed physician in charge of the clinical ward applied mercurial ointment to the whole face.

⁶⁵⁴ See appendix 2 for descriptions of all pharmaceutical terms and medicines.

⁶⁵⁵ James Anderson, 'Notes on the Lectures of John Redman Coxe', HSP.

⁶⁵⁶ Ibid.

⁶⁵⁷ Bitner, 'Note's taken from the Philadelphia Almshouse', 1810.

Benjamin Smith Barton and Nathaniel Chapman

Chapman's lectures and personal papers are especially illustrative of almshouse therapy. The doctor served as resident physician between 1804 and 1832 for several decades and was highly influential amongst his students, many of whom subsequently practised in the almshouse. 'In the management of Gonorrhoea' Chapman explained 'every one disdains the utility of mercury at least in its primary stage'. Thus, it would seem Chapman and some of his colleagues objected to the use of mercury in this stage of the disease. As outlined, Chapman appears to have been quite progressive in distinguishing different manifestations of venereal diseases, concluding that they required specific therapy. This was in contrast to physician Benjamin Smith Barton, whose practice may have been typical of those physicians who were castigated by Chapman. Barton (who was closely linked to the Pennsylvania Hospital) relied on a form of mercury for gonorrhoea, recommending a mixture of calomel and opium. The dosage he recommended was nothing short of "heroic" with the opium mixed with 20 grains of calomel. Rush's abrasive 10 and 10 seems tame by comparison. Moreover, as he also explained to his students, 'I have used injections of Corrosive Sublimate but the Calomel injection is better'.⁶⁵⁸ Yet Barton -who practiced for one year only at the almshouse- held views on treatment of venereal disease that were unrepresentative of infirmary doctors.

Benjamin Ellis was the outdoor physician appointed by the Guardians of the Poor to visit sick paupers in their homes. He also published a collection of prescriptions in the *Medical Formulary*, which are instructive of the Philadelphia medical community's preferences for herbal medicines.⁶⁵⁹ For a prescription using Balsam of Copaiba, Ellis wrote, 'this remedy is more especially used in gonorrhoea, and is considered by Professor Chapman as specific in that disease'.⁶⁶⁰ Sure enough, Chapman's personal pharmacopeia corresponds, and he stated his preferred method for gonorrhoea particularly forcefully,

...ever since I commenced the practice of medicine I have trusted to the Balsalm Copaiba alone in this disease....I give it from the very commencement of disease regardless of the inflammatory symptoms.

⁶⁵⁸ Thomas D. Mitchell, 'Notes on the Lectures of Dr. Benj. L. Barton, 1809-1810', CPP.

⁶⁵⁹ Benjamin Ellis was also connected to the Philadelphia Dispensary, and acted as elected out-door almshouse physician and accoucheur from 1827 to 1831. Agnew, 'Medical History'.

⁶⁶⁰ Ellis, *Medical Formulary*, 74.

According to Chapman, '40 or 50 drops morning noon and evening generally effects a cure in 4, 5 or 6 days'. Moreover, he also stated that 'the utility of B[alsam] C[opaiba] in this disease does not rest on my solitary authority alone' and he pointed towards others 'in this City [who] use it'. If the gonorrhoeal complaint was stubborn and would not yield to the balsam, Chapman stated that 'none answer better or is more generally employed than the following: 10 grains of zinc sulphate mixed with 1 teaspoon of laudanum and 2 tablespoons of Gum Arabic'. He referred to the 'wide' use of this formula, which suggests his almshouse colleagues also relied on this. He also noted, that if these are not 'fully sufficient to effect a cure...the best injection in these cases is one of opium and camphor'.⁶⁶¹ Revealingly, mercury was absent from all of these treatments for gonorrhoea.

For cases of chancre, Barton's views may have been typical of a number of American and European doctors who followed aggressive regimens. As he lectured to his students, 'I do not believe that chancres have ever been cured by anything but mercury'.⁶⁶² Oscar Reiss has suggested that during the Revolutionary war, it was common practice for doctors to treat soldiers with mercury for an initial syphilitic ulcer -usually a chancre- and if it did not respond, 'it was treated with a saturated decoction of guaiacum or sarsaparilla'.⁶⁶³ In contrast, Chapman appears to have done quite the reverse and resorted to mercury in the last instance.

The different medical beliefs and strategies of almshouse doctors would have had an enormous effect on their patients. Diseased women arrived at the almshouse with all types of ulcers, many of which were not actually venereal. As noted above, Chapman was meticulous in diagnosis, claiming that the majority of 'ulcers which I allude to are of the *nature* of Chancre and they run the same course'. However, he continued 'they may be distinguished from real Chancres, when there is no venereal taint'. Primary syphilis is characterised by chancres, (ulcers) or buboes (swelling) when the disease is at its most infectious. Chapman clearly differentiated between the various

⁶⁶¹ Bitner, 'Notes' (1810); Abraham Bitner, Chapman's Lectures on the Practice of Physic, Vol.2. In addition, he also recommended 'the uva ursi ... [as] a far better remedy...more than once I have cured this complaint by this alone'.

⁶⁶² Mitchell, 'Notes of Barton'.

⁶⁶³ Reiss, *Medicine and the American Revolution*, 161

stages of syphilis and gonorrhoea, and this is also demonstrated in his medical practice at the Philadelphia Almshouse. Recall Chapman's views that, 'nothing is clearer to me than that there is a *specific* difference between them'. His confidence in this aspect of venereal disease derived from 'a work...by Richard Carmichael in which my views are fully verified'.⁶⁶⁴ In cases of real chancre or primary syphilis his preferred remedies were,

caustic Alum or carbonate of Lime, water will answer, after which it is to be washed with stimulating lotions...if it is flabby decoctions of Peruv[ian] Bark must be used...if it is irritable wash of any of the Narcotic articles-a solution of Opium is good, but a decoction of Cicuta is to be preferred.⁶⁶⁵

He also noted, 'in recent attacks very slight salivation will suppress it...with local applications'. This he carried out with applications of caustic, noting 'never have I found it necessary to prescribe mercury in recent cases'. Thus, as he continued,

... [for syphilis] it is safe to use local remedy. If consulted on the incipient stages of syphilis, my practice is at once to destroy the chancres so effectually, that it won't affect the constitution. This may be done with Caustic. The Chancre is then converted into an ordinary ulcer which can by proper treatment be healed in a very short time.⁶⁶⁶

Chapman therefore proposed 'caustic and stimulating applications [made] with a solution of brandy...decoctions of Bark or Tincture of Myrrh' and if the ulcer was stubborn, he also recommended a 'minute dose of corrosive sublimate'.⁶⁶⁷ Although in the treatment of syphilis Chapman explicitly stated 'No Mercury is to be given', he did note, that if all else failed and the condition appeared beyond repair, only then should the practitioner resort to mercury, which he recommend as local mercurial dressings.⁶⁶⁸ 'There is a vulgar notion' reported Chapman, that 'in Lues Venerea the whole system is saturated with the [venereal] poison which can only be corrected by the use of mercury'. In what was clearly an attack on practitioners like Barton and Rush, he declared, the consequences of this can be in many cases be very severe & in many instances it has induced what is called the Merc[sic] Disease which is more

⁶⁶⁴ Bitner, Chapman's Lectures, Vol.2.

⁶⁶⁵ Chapman, 'Notes' (1810).

⁶⁶⁶ Ibid.

⁶⁶⁷ Chapman seems to have taken some of his ideas from the Dublin Lock Hospital physician. He notes that in cases of stubborn ulcers he terms 'pseudo syphilitic', 'Carmichael trusts a weak solution of one grain corrosive sublimate mixed with lime water. Chapman, 'Notes, Vol.2', 282.

⁶⁶⁸ Underlined by Chapman.

horrible than the Ven[sic] Disease itself'. For the treatment of syphilis, he was particularly explicit in his opinion of the tendencies of medical men to employ excessive doses of mercury. As he explained, 'in cases of genuine syphilis...my own experience tells me that we frequently, most wantonly and unnecessarily push mercury too far'.⁶⁶⁹ Ointment -as opposed to pills and fumigations- he found 'more safe' and less 'deplorable' in its effects. Moreover, there was precious little room for the procedure of salivation in Chapman's personal *materia medica*. He did suggest however, 'in recent attacks' salivation will only answer if 'never carried to any height'. The salivation, 'should always be slight, and the...mineral acids employed in conjunction with a decoction of Sarsaparilla or Guaiacum'. The acid he refers to was 'the nitric acid [which] has been too much overlooked...it answers best when ulcers are large...and painful'.⁶⁷⁰ It would seem Chapman's definition of salivation did not envision the use of mercury. In fact, he also contended of salivation, 'I have never found it necessary between the first appearance of a chancre and the occurrence of constitutional symptoms'.⁶⁷¹ I have examined the evidence from Chapman's lectures in addition to his own notes, and it seems his opinions were firm and unchanging through the entire period.

Chapman despaired of medical men who resorted to salivation. He described one patient admitted to the almshouse, 'who had been salivated for the venereal disease 18 months ago'. The mercury that induced the patient's salivation had been employed elsewhere, and the patient had not fallen 'under my notice & who had not taken mercury during that period'. Consequently he explained, mercury 'will remain dormant for a long time in the human system', thus he diagnosed his patient as suffering from mercury poisoning rather than venereal infection itself.⁶⁷² The above comment is telling. As resident almshouse physician, Chapman was convinced that

⁶⁶⁹ Ibid.

⁶⁷⁰ Chapman's protagonist Carmichael stated a similar regimen for syphilitic ulcers: 'I have made many trials of decoction of guaiacum wood...but I place much more reliance on sarsaparilla'. Carmichael, *Essay*, 193. Botanical remedies, like metallic and minerals were as many and varied in the treatment of venereal diseases. As one author noted, 'very numerous and different are the prescriptions of decoctions of the woods...both the vegetable and mineral kingdoms were thoroughly ransacked and attentively examined...by a series of experiments; and even at present we are sometimes under the necessity of having recourse to both'. The author firmly contended, 'let it be remembered however, that vegetables alone, when prepared properly, will effect a cure in many cases.' Charles Swift, *Salivation Exploded: A Practical Essay on the Venereal Disease, Demonstrating Fully the Inefficacy of Salivation* (London: 1782), 12.

⁶⁷¹ Chapman's Lectures, Vol. 2

⁶⁷² Ibid.

the patient had not been previously treated in the almshouse because he simply did not come under the doctor's notice. This suggests Chapman did play a profound role in the almshouse wards, and paid careful attention to all his venereal patients. By not recalling this patient in the almshouse ward, the physician seems certain that he must have been treated outside the almshouse. His confidence in this fact also adds weight to the argument that salivation was rarely employed in the infirmary, given that he would have recalled the practice.

Chapman was resolute in his views, and firmly believed that many patients he attended to suffered from the effects of mercury poisoning rather than venereal disease. His beliefs suggest that many diseased women who arrived at the almshouse had been exploiting mercury elsewhere in Philadelphia's medical marketplace. Moreover, a number of these women probably only suffered from common ulcers in the first place, yet they had presumed themselves venereal. As Chapman claimed, 'this is so true that I may lay it down as a Rule, that in most cases we have only to counter-act the effects of the mercury'.⁶⁷³ In Europe the effects of mercury poisoning were mostly blamed on syphilis itself.⁶⁷⁴ Yet Philadelphia physicians seem to have been more open-minded about the effects of syphilis than their European counterparts.

Philip Syng Physick and John Syng Dorsey

A further almshouse physician, John Syng Dorsey, noted his thoughts on mercurial poisoning, 'ulcers [resulting] from the use of mercury generally get well when the medicine is discontinued'.⁶⁷⁵ Moreover, Dorsey only advised the use of mercury in later stages of disease. As he told to his students,

...when notwithstanding a vigorous perseverance in the use of the preceding medicines, either the pith of saasafras or mild zinc sulphate, and the inflammation continues unabated...mercury should be administered.⁶⁷⁶

⁶⁷³ Ibid.

⁶⁷⁴ Quétel, *History of Syphilis*, 86.

⁶⁷⁵ Dorsey's uncle influenced him immensely as a surgeon. At the Philadelphia Almshouse and Pennsylvania Hospital he assisted his Physick with patients and kept daybooks and notes of his clinical experiences. These are recorded in, John Syng Dorsey, *Elements of Surgery: For the Use of Students* (Philadelphia: Edward Parker, 1813). Philip Syng Physick was elected as medical appointee to the almshouse in 1801 after Samuel Duffield was removed for admitting a fever patient. Agnew, 'Medical History', 10-11. Dorsey was elected twice as an almshouse medical appointee.

⁶⁷⁶ Dorsey, *Elements of Surgery*, 324.

To do this he proposed only ‘two or three grains in twenty-four hours’. Dorsey was referring to a case of ophthalmia, which was often caused by gonorrhoea. This almshouse physician was clearly dubious about the use of mercury in general, and acknowledged its abuse. In the case of a swollen trachea, he was aghast that ‘in some cases the tongue has become so much swelled from the use of mercury’.⁶⁷⁷ Dorsey’s uncle, Dr. Physick -a physician in both the almshouse (1801) and Pennsylvania Hospital- also left his thoughts on venereal treatment. He said of his colleague Benjamin Smith Barton, ‘I have tried Dr. Barton’s methods and I think he is wrong.’⁶⁷⁸ Physick seems to have concurred with Chapman and others who claimed that ‘mercury is seldom necessary in gonorrhoea’. Physick also lectured to his students on the benefits of caustic as a therapeutic agent. He claimed, venereal warts that are ‘subject to chancre (primary syphilis)...and sometimes a consequence of gonorrhoea’ should be simply ‘touched with caustic’. Yet he also noted that when ‘chancres are so situated as not to be easily reached by caustic...mercurial washes be useful’.⁶⁷⁹ In accord with other Philadelphia almshouse doctors, Physick contended that gonorrhoea and chancre were primary stages of syphilis, yet like other physicians mentioned, he was definite on the fact that they should not be treated as if they were the same disease. He explained, ‘you might suppose gonorrhoea can be cured by syphilitic remedies...but it is not the fact’.⁶⁸⁰

From the above evidence then we can begin to reconstruct the venereal ward therapy. It would appear that diagnosis in the almshouse venereal ward was more nuanced and treatment more measured than may have been the case in Rush’s Pennsylvania Hospital. Mercury was only used as a last resort, and then in the most mild forms in late stages of disease. While practitioners were nevertheless still in favour of purging or depletion there was a willingness to embrace other minerals, or various roots and barks to promote gentler sweating or purging. In short, Philadelphia’s almshouse was guarded by an ‘anti-mercurial brigade’ rather than a ‘calomel brigade’.

⁶⁷⁷ John Syng Dorsey, *Elements of Surgery*, 324, 443.

⁶⁷⁸ Thomas D. Mitchell, ‘Notes on the Lectures by Physick’, 1810, HSP.

⁶⁷⁹ Ibid.

⁶⁸⁰ Ibid.

5.8 The doctor and his patient

The French clinical school influenced not only diagnosis and treatment in the almshouse, but also the relationship between doctor and patient and at the bedside. As outlined above, during the late eighteenth and early nineteenth centuries France became the hotbed of anatomical research and clinical instruction, which directly impacted on Philadelphian physicians.⁶⁸¹ According to William Stempsey, there existed a 'growing awareness of the reputation of the Paris hospitals' amongst the American medical community.⁶⁸² Recall the tribute given to almshouse doctor Coxe as one of those who rehabilitated Hippocrates. Coxe and his associates were part of a revival of empiricist philosophy marked by new insights derived from a genesis in medical education, which had been brought about by increasing numbers of hospitals. These sites provided greater training as doctors were now observing literally hundreds of patients.⁶⁸³ The growing emphasis placed on hospital-based teaching was as much a consequence of the Britain's voluntary hospitals, in addition to the Parisian 'revolution' of hospital teaching.⁶⁸⁴

This departure from rationalist medical practice essentially promoted a greater reliance on bedside observation, physical examination and routine autopsy. One Philadelphia physician marvelled at the benefits of hospital education from the late eighteenth century, recalling that,

⁶⁸¹ According to Stephen Jacyna, 'so prominent was this French episode in collective memory that the period between the 1820s and 1850s came to be known as the Paris period' in American Medicine'. He also suggests that the empiricist ideology of the French school was particularly suited to these medical men because 'early American accounts tended to stress what the visitor saw and did'. See Stephen Jacyna, 'Medicine in Transition, 1800-1849', in William F. Bynum, Anne Hardy, Stephen Jacyna and Christopher Lawrence (eds.), *The Western Medical Tradition* (Cambridge: Cambridge University Press, 2006), 48-9.

⁶⁸² This was partly a consequence of the French presence in America, but was also 'influenced by the reports of the few Americans who were able to travel there in the very early years of the nineteenth century'. However the impact should not be overstated, as Stempsey notes, 'it should not be surprising that those returning from Paris should meet resentment from the American physicians who remained behind'. See William E. Stempsey, *Elisha Bartlett's Philosophy of Medicine* (Springer: Netherlands, 2005), 15.

⁶⁸³ Duffy, *Humours*, 71. On hospitals as sites of teaching see Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth Century London* (Cambridge: Cambridge University Press, 1996). On the growth of voluntary hospitals in Britain see Lyndsay Granshaw and Roy Porter (eds.) *The Hospital in History* (Routledge: London, 1991).

⁶⁸⁴ As we have seen, the Philadelphia Almshouse was comparable in ethos to the European poorhouses. Yet, it was nevertheless 'up there' beside institutions such as the Pennsylvania Hospital for the value placed on clinical teaching both in the wards of the infirmary and in lectures carried out on the almshouse site.

To extend as much as possible the field of observation, I exercised it not only in my private practice, but also in the Pennsylvania Hospital, and another public institution then within the city, called the Philadelphia Almshouse. Each of these institutions, more especially the latter...furnished me abundantly with subjects well suited to the purposes of enquiry.⁶⁸⁵

The evidence indicates that many Philadelphia practitioners leaned particularly heavily on the practical observations made during their ward rounds. Almshouse physician James Anderson's journal from 1804 is illustrative of this shifting pattern towards empiricism and the value placed on bedside observation. His case studies highlight a doctor's day-to-day methods of diagnosis, observation as well as patient care. He showed diligent attention to each of his pauper patients, regularly losing sleep to monitor their progress while the rest of Philadelphia slept. Anderson's journal also illuminates how several almshouse physicians were showing a tendency to modify the lessons of their mentors, and beginning to base their therapeutic practices on their own observations. Anderson frequently referred to individual doctor's orders for the best prescription of drugs, then later notes where he disagrees with those drugs dispensed, and explains to his preferences based on his own observations.⁶⁸⁶

Elements of French medical practice evolved in different places at different times in America. According to Jacyna certain key elements of French medicine would prove to be stable, most notably the requirements of hospital-based instruction, and also physical diagnosis together with routine autopsy.⁶⁸⁷ Dissections in the Philadelphia Almshouse and Pennsylvania Hospital date back to the early years of the nineteenth century, and a Hospital casebook dated 1803 includes post-mortem results for many 'atypical' cases; in the almshouse infirmary a similar practice is apparent from the early period.⁶⁸⁸

⁶⁸⁵ Charles Caldwell and Harriet W. Warner, *The Autobiography of Charles Caldwell M.D.* (Philadelphia, 1855; Reprint New York, De Capo Press, 1969), 263-4.

⁶⁸⁶ James Anderson, 'History of Certain Cases taken by the author as they occurred during his residence in the Philadelphia Almshouse, Oct. 1804 to May 1806'. HSP.

⁶⁸⁷ Jacyna, *Medicine in Transition*, 46

⁶⁸⁸ See for instance, *Guardians of the Poor*, Almshouse Hospital Medical Department Case Records, 1816. The almshouse played an important role in the field of scientific developments, and was the leading centre of midwifery, headed by William Shippen, and later, Chapman. Until the mid-eighteenth century, obstetrics was a female prerogative, yet from the 1760s this shifted into the hands of male physicians, led by Shippen in Philadelphia. According to Duffy, American surgeons ventured early into this field, and were certainly more ahead than their English counterparts. Duffy, *Healers*, 133-35; Shyrock, *Medicine and Society*, 23-4. The use of the speculum in gynaecological investigation is

However, while many American doctors welcomed the opportunities provided by practice in Paris hospitals, the objectification of patients did not sit well with them. Although the French school was embraced by American doctors, certain aspects of French patient care ‘repelled them’, especially the emphasis placed on clinical experience at the seeming expense of patient care.⁶⁸⁹ As a consequence, the American medical community became distrustful of the Parisian tendency to value science above healing. Moreover, as Jacyna points out by the 1820s the American medical profession had already carved a distinctive identity for themselves reflective of their French experiences. Yet, they would modify it to their own taste back home. By adapting it to the realities of American medicine, they would then cite their own methods as superior to the French model given the greater value placed on the care of the individual patient.⁶⁹⁰

Almshouse resident physicians and surgeons trained in an institution that cared for some of the city’s most unfortunate victims of poverty and illness, making for a distressing environment. In 1809 it came to the managers’ attention that the physicians of the female surgical and venereal wards were giving ‘meat, Sugar etc...over and above the established allowance of the house’.⁶⁹¹ Patient Care was important to American hospital physicians. Samuel Duffield and Capser Wister were particularly attentive to the plight of the poor. According to contemporaries, Wister possessed a ‘quiet and genuine philanthropy’ that had no bounds. In particular, Wister displayed exceptional sympathy for the plight of vulnerable, poor and minority population of Philadelphia.⁶⁹² Rush’s partner Charles Caldwell was frustrated by

apparent from the late eighteenth century, and the physicians listed these instruments as being held in the institution. Contemporary physician William Acton claimed that English doctors did not adopt genital instruments like the speculum, thus, as Wyke points out, the English remained deeply conservative in this field. For the importance of the almshouse infirmary in the area of midwifery see, Hunter, ‘Origin’, 44.

⁶⁸⁹ Foucault’s *Birth of the Clinic* has inspired numerous studies, and although most historians and sociologists agree with his analysis of the progress of Parisian clinical medicine, there is disagreement about how influential the philosophical underpinnings of the French ‘clinical gaze’ was to doctors. Foucault’s study turns the body into something to be observed, thus the patient is objectified and dehumanized. American doctors were selective in what they drew from French practices. Moreover, American medics also argued that the physicians of French hospitals disregarded such variables as demographic, meteorological and epidemiological national differences. Warner, *Therapeutic Perspective*, 185-199.

⁶⁹⁰ Jacyna, *Medicine in Transition*, 48

⁶⁹¹ 27 Feb, 1789, M.M.

⁶⁹² Whitfield Bell, *Colonial Physician*, 81. Samuel D. Gross, *Eminent American Physicians*, 136.

Casper Wister's apparent devotion to patient diagnosis in the almshouse infirmary and the Pennsylvania Hospital, charging him with an 'annoying thoroughness of his patients and their prescriptions'. As Caldwell claimed,

...his examinations into the symptoms of his patients, was always...minute, and fatiguing. He would, on some occasions, circumambulate the beds of the sick two or three times, eyeing their countenances from every point, feeling their pulses repeatedly, and interrogating them respecting the feelings experienced by them in almost every part of their bodies.⁶⁹³

In a similar vein, Kuhn was well known for his attention to care over his hospital charges. According to Francis Packard, Kuhn in particular was 'devoted to his patients and observation'.⁶⁹⁴ For Samuel Duffield who served for twenty-nine years as resident physician, one surgeon recalled his charitable and compassionate care towards his poor patients: 'one of two things is evident; either the doctor was not fond of money or was fond of work'.⁶⁹⁵

It also seems patients were given a voice. For reasons not entirely clear, an individual made a formal charge against an attending physician, and the managers announced an investigation to ascertain the 'truth of certain charges of neglect in the professional conduct of Dr. Peterkin'. After consultation with the relevant parties the committee appointed to investigate reported back to the managers declaring that, 'the charge has not been substantiated: but on the Contrary, a number of the Nurses and Patients have united'. Moreover, the nurses and patients claimed 'that his treatment has been satisfactory and that comb'd with strict attention he has always manifested a disposition of tenderness and humanity towards them'. The committee also noted 'that it does not appear that he has refused a call of a patient' and the case was thereby 'discharged from any further consideration on the subject'.⁶⁹⁶ As chapter two

⁶⁹³ Caldwell exasperated at the standing and reputation Wister enjoyed as a consequence of his 'great attention and cautiousness, sagacity and judgement'. Although Caldwell acknowledged Wister's merit as a physician, he belittled his achievements, and he seems to have used Wister's academic work as a measuring stick.. Caldwell, *Autobiography*, 130-6.

⁶⁹⁴ Francis Packard, 'How London and Edinburgh Influenced Medicine in Philadelphia in the Eighteenth Century', *Transactions of the College of Physicians* (1931), 21-2. We should remember that Kuhn and Wister worked in both the almshouse and Pennsylvania Hospital. Duffield, Hutchison and Chapman were connected solely with the almshouse infirmary.

⁶⁹⁵ Agnew, 'Medical History', 7.

⁶⁹⁶ 4 Sept. 1809, M.M.

highlighted, the physicians tired of campaigning for better patient conditions. They wrote to the managers in 1814 claiming,

We are impressed with a belief that the present situation of the sick in the Philadelphia Almshouse requires the humane executions of the Board of Managers to remedy the evils to which this suffering class of the community are now unavoidably exposed... We are *compelled* to be the painful spectator of scenes of human misery without having the power to apply restorative means...to the extent to which our judgements would dictate.⁶⁹⁷

Change in approaches to venereal therapeutics developed out of those occurring during the yellow fever epidemics. Rush's doctrines influenced a great many doctors, but it did not halt the transition already in place amongst a significant section of the medical community. Not all doctors followed the rationalist theories and drastic therapies employed by Rush, and his methods have generally overshadowed the work of his colleagues. A number of educated Philadelphia physicians drew upon therapeutic methods of doctors from Edinburgh, Paris and Montpellier. Philadelphia doctors, many of them in the almshouse, developed their own therapies which drew upon a pharmacopeia native to their country. Some almshouse physicians welcomed medicine that completely deviated from the professional norm by turning to the remedies sold by unorthodox practitioners. On the one hand the medical profession had a certain social position to cling to, yet the line dividing regular and irregular was blurred. By endorsing Swaim's *Panacea nostrum*, almshouse physicians such as Chapman did step over that boundary. However, Chapman was certainly held in high esteem by his contemporaries, and in Ellis's *Medical Formulary* it was noted that 'the arrangement framed by Professor Chapman for his Therapeutics, appearing to combine greater advantages than any other, we have taken the liberty of adopting it as the basis of this Formulary'.⁶⁹⁸

⁶⁹⁷ 24 Jan. 1814, M.M.

⁶⁹⁸ Benjamin Ellis's eighth edition of the *Medical Formulary* was in fact dedicated to 'Nathaniel Chapman, M.D. Professor of the Institutes and Clinical Practice in the University of Pennsylvania... Whose Talents and Urbanity have Raised Him to the First Rank in the Profession, and have Acquired for him the Confidence and Esteem of an Enlightened Community' Benjamin Ellis, *Medical Formulary: Being a Collection of Prescriptions Derived from the Writings and Practice of Many of the Most Eminent Physicians in America and Europe* (Philadelphia: Henry Lea), preface.

We should close this chapter with the mention of another Philadelphia doctor, Dr. Thomas Harris who was in charge of the Philadelphia Naval Hospital and also practised in the almshouse infirmary. Harris received an accolade in Carmichael's *Essay*, which had a profound influence on Chapman. According to the editor of the *Essay*, the port surgeon of Philadelphia,

for nearly six years has discarded every preparation of mercury from his practice...He further declares that he has found that variety of ulcer called the true Hunterian Venereal Chancre yields most readily to the non-mercurial treatment. ...The cure in cases non-mercurially treated has been conducted chiefly by the aid of rest, cleanliness, astringent applications...sarsaparilla, and the anti-phlogistic regimens.⁶⁹⁹

Carmichael's *Essay* was highly influential amongst the professional medical community. Many similar texts were published on venereal diseases during the nineteenth century, and most also included personal testimonies like this one. Yet there is no reason to treat these with scepticism. As Bynum notes, medical literature like this touting cures for venereal disease, which 'at first blush seem quackish' were in fact often 'open, honest and humane'.⁷⁰⁰ Carmichael was not trying to promote a patent remedy like William Swaim.

We began this chapter by considering how late eighteenth and early nineteenth century doctors have been treated by history; in short as callous, with Benjamin Rush seen as dominating medical ideas and practice in Philadelphia. Yet, the picture emerging is that many doctors were more sensitive to the needs of their hospital patients, and even those suffering from venereal disease elicited a degree of sympathy from contemporary physicians. It was not only sympathy but also a different approach to therapy based on new ideas of disease causation. Moreover, non-mercurial treatments for venereal disease were based upon different theories, supported by gentler therapeutic regimens. The next chapter will reconstruct the polishing room one step further, and probe the experience and treatment of venereal disease "from below", to ascertain to what extent almshouse physicians put into practice the ideas they expressed in their lectures.

⁶⁹⁹ Carmichael, *Essay*, 55.

⁷⁰⁰ Bynum, 'Wages of Sin', 6

Chapter 6

Reconstructing the Polishing Room: the view from below

6.1 “Her Face is One Ulcerous Scab”: the painful reality of disease

Like the historical imagery evoking unsympathetic doctors, there is a typical representation of diseased prostitutes. This image frames the prostitute as the disease itself: her nose crumpled and her body withered to a bag of bones by the effects of infection and mercury treatment. In short, the disease itself is personified.⁷⁰¹ To an extent, this cultural construction of venereal disease was the unfortunate reality for some women. During a visit to a Parisian foul ward in 1816, Glasgow surgeon William Mackenzie witnessed the debilitated state of a woman, observing, ‘in many cases the disease has become part of ourselves’.⁷⁰² Richard Carmichael witnessed comparable sights in the London foul wards he worked in. He despaired at ‘the unfortunate wretches [who] daily present themselves for advice...with the septum destroyed and exhibit one large cavity, the walls of which are a foul ulcerated cavity’.⁷⁰³ Similar observations may have been made by doctors in Philadelphia’s almshouse if they came across Margaret Jackson on their ward rounds. When Margaret was admitted in 1789, Cummings noted her as being ‘eaten up with the venereal disease’.⁷⁰⁴ To what extent was this sometimes hideous aspect of venereal infection typical of a prostitute’s experience?

This chapter will explore how women were treated for disease by exploring actual therapeutic practice inside the polishing room. In order to do so, we need to reproduce a picture of available drugs to gain an impression of what sort of treatment women were prescribed. This will offer a richer interpretation than the present historiography

⁷⁰¹ Historical accounts of diseased prostitutes is informed to a large extent by satirical art and popular print culture of the eighteenth century, which Porter points out was obsessed with ‘conveying the understanding of the body...and the practice of medicine’. Venereal disease is characterised throughout Hogarth’s *Harlot’s Progress* prints. In an image portraying the notorious brothel owner Elizabeth Needham, pock marks replace beauty marks. Roy Porter, *Bodies Politic, Disease, Death and Doctors in Britain, 1650-1900* (London: Reaktion Books Ltd, 2001), 15, 34, 96; N.F. Lowe, ‘The Meaning of Venereal Disease in Hogarth’s Graphic Art’, in Linda E. Merians (ed.), *The Secret Malady: Venereal Disease in Eighteenth Century Britain and France* (Kentucky: University of Kentucky Press, 1996), 168-82.

⁷⁰² William Mackenzie M.D., *Diary of a Tour and Residence in France, Switzerland, Italy, Austria, Prussia and Germany, 1816-1818*, Royal College of Surgeons and Physicians, Glasgow, 6 June, 1816.

⁷⁰³ Richard Carmichael, *Essay on Venereal Diseases, and the Uses and Abuses of Mercury in their Treatment, Second American Edition*, (Judah Dobson: Philadelphia, 1825), 209.

⁷⁰⁴ Margaret Jackson, Dec. 1789, Dockets.

on prostitution and pauper therapeutics. Such an analysis should also provide a greater understanding as to why women responded to almshouse care as outlined in chapter three. Many diseased women were acquainted with the nature of almshouse therapy, and could therefore comprehend what treatment they would receive at the infirmary. As such, diseased women selected this in preference to medicines available elsewhere. This chapter will argue that women did not elope from the venereal ward simply because their treatment was ghastly -as has been suggested by historians- but rather, as legitimate customers many shopped for what they perceived to be the best treatment.⁷⁰⁵ Drawing on the evidence presented in the previous chapter we can also assess whether the lessons imparted by almshouse doctors on venereal therapeutics translated into practice on diseased women. Thus we can respond to Ackercknecht's challenge to determine whether doctors practiced what they preached.

As noted, historians have a tendency to assume that medical treatment in workhouses or almshouses simply reflected the punitive nature these of institutions.⁷⁰⁶ In a fleeting reference to prostitutes' medicine at the Philadelphia Almshouse, Richard Godbeer claims that,

...the prominence of abrasive therapy meted out by almshouse physicians is underlined by the official record's repeated description of the ward set aside for that purpose as the polishing room.⁷⁰⁷

This he also attributes to the 'clerk's' frequent use of nautical metaphors to characterize prostitutes. Yet, the author's source for this contention is the use of anecdotal evidence left by the 'clerk' (who was in fact the steward John Cummings). Moreover, Godbeer also bases his assertion on a reading of Scottish doctor John Hunter's 1786 *Treatise on Venereal Disease*. From these sources he claims, medical experts 'were virtually unanimous in arguing that mercury based therapies were by far the most effective in combating both "local" and "constitutional" manifestations of

⁷⁰⁵ Kevin Siena, *Venereal Disease, Hospitals and the Urban Poor* (New York: University of Rochester Press, 2004), 130-1. Siena suggests foul patients in London's Royal Hospitals absconded because they could not endure the horrors of drastic mercury treatment. This interpretation is more reflective of the Pennsylvania Hospital. See Appendix 5.

⁷⁰⁶ For an example that deviates from this interpretation, see Jonathan Andrews, 'Hardly a Hospital but a Charity for Pauper Lunatics: Therapeutics at Bethlem, in Barry and Jones, (eds.) *Medicine and Charity Before the Welfare State* (London: Routledge, 1991), 63-82.

⁷⁰⁷ Richard Godbeer, *Sexual Revolution in Early America* (Baltimore: John Hopkins University Press, 2002), 320. The managers only rarely referred to the ward as the polishing room, and the physicians never used the term.

the disease'.⁷⁰⁸ For Hunter, venereal diseases in all forms were only curable with the use of mercury, yet his thesis provoked controversy, and in Philadelphia medical opinion dictated otherwise. There is little evidence in the Philadelphia records to justify Godbeer's claim regarding the use of abrasive therapy.⁷⁰⁹ Historian of Philadelphia prostitution Marcia Carlisle made a similar claim in a fragment of information pertaining to venereal disease, claiming 'all cures were mercury'. In a similar vein, Hills suggests that in New York, prostitutes 'treatment depended on mercury cures or surgery, the most gruesome of all procedures'.⁷¹⁰ Historians have suggested that venereal warts were surgically removed by cutting or cauterization, sometimes with hot irons applied directly to the body.⁷¹¹ However there is no evidence of this procedure in the almshouse, which did not find any popularity amongst the medical profession in any case until the 1870s.⁷¹² In short, it has been taken for granted that mercury was the touchstone of a prostitute's medical treatment.

⁷⁰⁸ Ibid., 320. As noted, Siena does provide instances where patients were 'in salivation'. Yet his period is of a slightly earlier date, and as this discussion has also revealed, English practitioners were more predisposed to the use of mercury than was the case on the continent.

⁷⁰⁹ As suggested, the steward did so as a source of amusement, which was ultimately a coping strategy. I would be hesitant at taking this label of prostitutes and the venereal ward at face value. The use of nautical metaphors to depict prostitutes was in fact commonplace from the early eighteenth century, particularly amongst sea farers in the port towns of England. This may have been derived from the famous pimp Jack Harris's use of maritime terminology in his directories of local prostitutes, (*Lists of Covent Garden Ladies*) in particular those who catered to sailors in 1740s London. For evidence that nautical analogies were common in England see London physician Charles Swift's encounters with prostitute patients. One of his patients 'said she supposed it would be necessary to undergo a thorough repair'. Charles Swift, *Salivation Exploded* (London, 1782), 42.

⁷¹⁰ Carlisle, *Prostitutes and their Reformers*, Unpublished PhD. Thesis (1982), 49; Hill, *Sister's Keepers*, 233 (this was however a later period in the nineteenth century, when it has been suggested that mercury made a brief come-back on both sides of the Atlantic). Also see Linda Mahood, *The Magdalens: Prostitution in the Nineteenth Century* (London: Routledge, 1990), 36-7; Siena, *Venereal Disease*, ch.4; Katherine T. Corbatt, *In Her Place: a Guide to St. Louis Women's History*, (St. Louis: Missouri Historical Society Press, 1999), 127.

⁷¹¹ Godbeer infers that this was almshouse practice because Hunter's treatise included a description of cutting warts with a pair of scissors. Godbeer, *Sexual Revolution*, 320. Trumbach shows this was the case in an eighteenth century London Lock Hospital, as illustrated by a woman who was too scared to go back and 'be cut again'. There is no reference to cutting in any of the Philadelphia sources consulted, and that caustic salts were more commonly employed to remove aggressive warts and applied locally till warts fell off. Randolph Trumbach, *Sex and the Gender Revolution* (Chicago: University of Chicago Press, 1998), 220.

⁷¹² Although excision became popular from the 1870s, it lost favour very quickly given that the consequent mutilation of the patient, and the fact it did not prevent secondary symptoms. Claude Quétel, *The History of Syphilis*, translated from the French by Judith Braddock and Brian Pike (London: Polity Press, 1990), 117. Wyke claims that only in acute cases was cauterisation resorted to, and this was not until the late nineteenth century. Wyke, 'Hospital Facilities', 82; Also see, Temkin, 'Therapeutic Trends', 309; Wooten contends that cautery was favoured by Hippocrates yet was largely abandoned during the Renaissance period. David Wooton, *Bad Medicine: Doctors doing Harm since Hippocrates* (Oxford: Oxford University Press, 2006), 31-2.

How a woman physically suffered infection is an important consideration if we are to account for patient experience. In an age without penicillin the disease could be painful, lifelong and debilitating. A diseased woman faced immeasurable health problems once her body was consumed by infection, being susceptible to a range of other ailments, particularly if she reached the secondary or tertiary stages. Thus, Cath Hayes was 'scarce able to crawl with the venereal'. Ann Hamilton was admitted having 'caught venereal disease at Polly Means' brothel only '2 mos ago', yet by the time she was admitted to the ward she was in such a 'low and emaciated state' she died the following month. Scores of women were noted as 'highly pox'd', 'very far gone' or simply 'the foulest'. Ann Smith was typical of several diseased patients. When she arrived in a cart to the almshouse Ann was completely disfigured by disease, her face being 'one ulcerous scab'.⁷¹³ Her body had been ravaged by the disease so far as to render her permanently physically deformed. She was previously admitted with a simple ulcer and during a later visit to the ward she complained of a sore leg. Thus we can see the progression from primary to secondary syphilis. The toxic effects of mercury could also take its toll. Brought in a cart to the almshouse, Hannah Giles had apparently 'lost the use of her limbs from too much familiarity with the mercury'. This was her first admission and it is likely that prior to arrival at the almshouse she had self-medicated or sought treatment elsewhere. Hannah was discharged from the infirmary the following month more or less disabled. An overwhelming number of women were admitted for the first time in such a physically impaired state that mercurial compounds were surely previously administered. As outlined in chapter four, a Philadelphia resident could quite easily purchase mercury and it would seem many diseased almshouse women did so in large doses. Several first-time admissions were noted as 'lost her nose from too much mercury' or 'blind from the effects of mercury'.⁷¹⁴

As the disease worked its way through a woman's body physical pain could be excruciating, and when it led to death it could be a protracted process. In the mid-nineteenth century, a New York physician estimated that the 'average duration of a

⁷¹³ Cath Hayes, Nov. 1790; Sarah Milford, Feb. 1796; Ann Hamilton, Dec. 1803; Ann Smith, Dec. 1793, Dockets, Sick paupers arrived at the almshouse in a cart when they were desperately ill, which was the eighteenth century ambulatory equivalent.

⁷¹⁴ Hannah Giles, 16 Aug. 1792, 27 Sep. 1792; Ann Hamilton, 17 Jan. 1802, 17 Feb. 1802, Dockets.

prostitute's life is only four years' if her disease went unchecked.⁷¹⁵ For many others it was painfully longer and the records illustrate just how long some women had to endure their symptoms before they eventually expired. As an example we can trace Mary Carlisle's experience through the records of two institutions. We first met the 'abandoned prostitute' in the early 1790s when she appeared in the almshouse and jail records. Mary used the almshouse habitually for a 'quick-fix'. It turns out Mary had been previously been treated for venereal infection in the Pennsylvania Hospital previously as a 'pay patient' in 1785, and again the following year she paid her own security. Carlisle's case provides an illuminating example of a woman impoverished as a consequence of disease. Mary then went to the almshouse infirmary on ten occasions between 1792 until she died in 1804. Thus from the evidence we have on Mary, it is clear that she suffered for nearly twenty years. In 1791 she was supposedly 'stout and healthy' with a 'sore finger' despite previous admission to the alternative voluntary hospital, yet by 1794 she was in the 'foulest condition'.⁷¹⁶ We also know that she was in an advanced state of disease by this time because she was transferred to the Pennsylvania Hospital on this occasion for special treatment. This voluntary hospital's records have her registered as a 'charity' patient whose 'security [is] paid by John Cummings'. By the early years of the nineteenth century she was so 'sick and diseased' that she died from venereal infection.⁷¹⁷ For a diseased woman then, illness could potentially be long-lasting and no doubt appalling to endure.

A woman's experience was compounded further by the susceptibility of the diseased body to a range of unrelated illnesses. Diseased women living in late-eighteenth century Philadelphia were particularly vulnerable to recurring yellow fever epidemics. Social commentator Mathew Carey was particularly explicit with his views, and he recalled of the epidemic's victims,

...to the tipplers and drunkards and those of a corpulent body of habit...the disease was very fatal...to the fille de joise it has been equally fatal, the wretched debilitated state of their constitutions, rendered them an easy prey to this terrible disorder which very soon ended their career.⁷¹⁸

⁷¹⁵ William Sanger, *The History of Prostitution: Its Extent, Causes and Effects Throughout the World* (Harper: New York, 1859), 676.

⁷¹⁶ Mary Carlisle, 15 Sep. 1785, 22 July 1786, Penn. M.M; Jan 1791, Feb and June 1794, Dockets.

⁷¹⁷ Mary Carlisle, May 1801, April 1804, Dockets. Feb. 1794, Penn. M.M.

⁷¹⁸ Mathew Carey, *A Brief Account of the Malignant Fever, which Prevailed in Philadelphia in the Year 1793* (Philadelphia: Clark & Braser Printers, 1830), 66.

Yellow fever struck a double blow to prostitutes who also acted as domestics, and Carey observed that ‘to hired servant maids it has been very destructive’. If the cards weren’t already stacked against diseased prostitutes enough, there was extra misfortune for women such as Lydia Oakman and Sarah Thompson, who lived in Southwark’s Plumb Street neighbourhood. Plumb Street was a dark alleyway as were many of its surrounding neighbourhoods, and as Carey pointed out, ‘the mortality in confined streets, small alleys and close houses, debarred of a free circulation of air...has exceeded in a great proportion that in the large streets and well aired house’. In some alleyways, he continued, ‘a third or a fourth of the inhabitants are no more’.⁷¹⁹ Sailors and immigrants who docked at Southwark’s quaysides spread a host of diseases, most notably fevers and dysenteries that diseased women would have lacked immunity to. Southwark prostitutes like Elizabeth Evans who was ‘venereal and diseased in other ways’ were therefore constantly at risk from catching other infections.⁷²⁰

A woman who suffered excruciating pain or advanced symptoms was no doubt very frightened, and the element of ‘choice’ rarely motivated a decision to go to the almshouse in such a case. Neither was there room for choice when a diseased woman was sent to the infirmary straight from jail or the Magdalen Asylum, or for those who simply had an empty purse. Yet there is a bigger picture. Many women turned up for treatment on one occasion only and the evidence implies many from this group were treated for minor complaints. The previous chapter emphasised that diseased patients were not always truly venereal regardless that admission registers could indicate otherwise. We cannot be totally certain what patients were actually being treated for, and when some women turned up at the infirmary they tended not to list their symptoms as being strictly venereal. They complained of a plethora of ailments to the steward, including ‘sore head’, ‘dizziness’ and ‘painful limbs’. Conversely, medical attendants would sometimes list a woman’s symptoms as ‘chancres’, ‘pox’d’, ‘ulcerous and rhumatick’, ‘remains of old disease’, ‘sore legs [the] effects of venereal disease’ or simply ‘syphilitic’. Numerous women were admitted displaying lesser

⁷¹⁹ According to Carey, seven-eighths of those who succumbed to the fever were drawn from the pauper class. Ibid.

⁷²⁰ Elizabeth Evans, Aug .1797, Dockets.

symptoms, which were either common or minor venereal ulcers, while others arrived with altogether separate gynaecological problems, which were associated or mistakenly diagnosed as venereal symptoms. For example, prostitute Sarah Brown had ‘various swellings’ and Sarah Halstead was admitted with ‘some trifling complaints’ resembling the ‘pox’ including ‘sore eyes and an itch’.⁷²¹ These women were actually treated to therapy low on mercurial applications if any at all as is shown below. And they often never returned. Therefore, the experience of venereal disease was not monolithic. Symptoms ranged from quite minor ulcers and sores (venereal and non-venereal) to severe secondary or tertiary syphilis.

Diseased women’s experience was also shaped by the fact that venereal infection could be a highly gendered affair. Men were able to draw upon more institutional medical resources, and foul beds in the Pennsylvania Hospital generally catered for the male labouring poor. Like the British voluntary hospitals, the ethos was to cure the sick man so he could return to his job, thus contribute positively to his family’s survival and the city’s economy. As outlined in chapter one, impoverishment was also gendered, which certainly played a huge role in a woman’s experience of venereal disease. This often motivated a woman’s decision to elope from the venereal ward so she could return to her children. Moreover, it is plausible that men suffered less humiliation than women, particularly in the institutional setting where patients had to expose their illness in all its glory to a medical team comprised of men. The flipside however, was that men may have felt more mercurial pain than women. This could be either through possessing a greater disposable income that could pay for commercially available mercury or a bed in the Pennsylvania Hospital, which carried more peril than the almshouse and perhaps venereal disease itself. This is also why so many prostitutes became very sick, simply because they could afford to purchase mercury early in their disease.

6.2 Deciding to go to the Almshouse Infirmary and Arrival at the Venereal Ward

⁷²¹ Sarah Brown, Aug. 1794, Sarah Halstead, April 1791, Dockets.

When did a woman report her symptoms to the infirmary? The nature of the disease made it possible to delay treatment. Gonorrhoea can often remain hidden from a woman, particularly because it can be painless in its early stage. In early syphilis the site of infection could be concealed, yet once advanced to its more visible secondary phase the disease would often be accompanied by offensive skin disorders. The New York physician William Sanger noted that by this point, 'syphilis...would be so disgusting that no prostitute could retain her place in a brothel'.⁷²² The Dockets imply that many diseased women ignored the disease given that they turned up for a first admission to the infirmary in a dreadful state. Sanger also remarked that 'it is rare prostitutes would acknowledge sickness if they could avoid doing so'.⁷²³

On the other hand, the evidence from the almshouse also suggests that many women sought almshouse treatment from the commencement of visible symptoms. This suggests that they were aware of the consequences if the infection was ignored. And many of this group only came once to the infirmary. According to Sienna, the average venereal patient in London waited twenty-six weeks before reporting symptoms. Sienna's evidence is taken from Dr. Pearson's lock hospital casebook, a quite detailed source. The earlier Philadelphia Almshouse records make it impossible to answer a similar enquiry. However, the 1860's Almshouse Prostitutes Register allows tentative conclusions. In fact, analysis of data extracted from the Register yields quite different results from London's lock hospital patients. The Register is based on interviews between the Philadelphia Guardians of the Poor and 250 patients who sought medical treatment at the almshouse. Table 7 is compiled from a statistical analysis of responses given by women to questions related to their disease while working as a prostitute, or alternatively, when they had become infected by a partner.⁷²⁴

⁷²² Sanger, *History of Prostitution* (1859), 597.

⁷²³ Ibid.

⁷²⁴ Out of a list of twenty-eight in-depth questions, the queries pertinent to this analysis include, 'how old are you...when did you become a prostitute...what age were you when you first became a prostitute...what age were you when first diseased...how often have you been in the almshouse hospital...how many times have you been in another hospital'? Clearly there are limitations concerning the validity of this source. Although the Register can be read as first-hand testimony, many women would have rehearsed the 'right' or most morally acceptable answer. Moreover, while some women provided lengthy responses, the Guardians appear to have guided women towards stock-phrased categorised answers, especially when querying a women's social background. (It is likely the Guardians borrowed William Sanger's interview techniques from his empirical investigation of 2000 diseased prostitutes in New York's Bridewell Prison in the 1850s). That said, diseased Philadelphia almshouse women still chose the category that most suited them, and when questions required a numbered response (pertinent to this analysis) such as age and how long they had been diseased, there

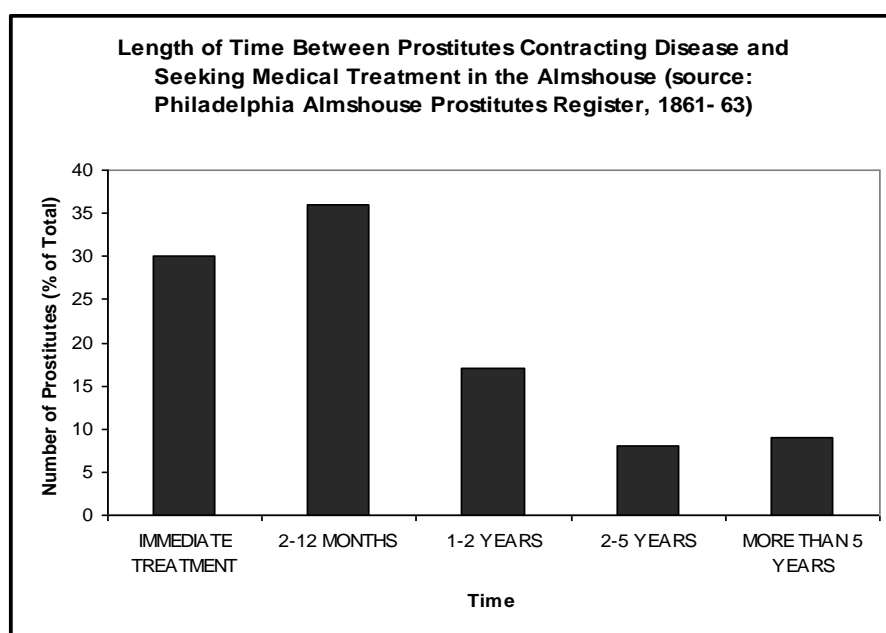


Table 7: Length of Time between Contracting Disease and Seeking Almshouse Treatment. (n=250)
Source: Guardians of the Poor, Philadelphia Almshouse Prostitutes' Register, c. 1860-1863 PCA

Frances Finnegan infers that York's poorhouse prostitution 'must have been infected for some time and continued in the occupation until their condition absolutely prevented it'.⁷²⁵ This is a fair statement to make for a proportion (roughly 35 percent) of Philadelphia women who in all probability previously self-treated. For example, 11 percent waited more than five years until seeking medical attention, many of whom were in a decayed state. Yet, a sizeable number appear to have acted quickly when they recognised the first symptoms. For example, nineteen year old Irish immigrant Johanna Donnohoe had worked less than two months as a prostitute when she became infected, and when she first noticed the disease she headed straight to the almshouse infirmary. Surprisingly over thirty percent sought treatment within the first two months, some even within the first weeks of noticing symptoms.⁷²⁶ Philadelphia's medical marketplace in 1860 was not dissimilar to the earlier period and venereal sufferers still had varied recourse to healing. Despite the host of irregular doctors and cheap patent remedies available, like their predecessors diseased almshouse women of the later period often selected the almshouse as a first choice amongst many.

was only so much skewing of evidence a woman could do. Therefore, while they may have been economical with the truth and the Register cannot provide definitive conclusions, it is nevertheless a rich source when critically read. Register, c.1860-63.

⁷²⁵ Frances Finnegan, *Poverty and Prostitution: A Study of Victorian Prostitutes in York* (Cambridge: Cambridge University Press, 1979), 158.

⁷²⁶ Johanna Donnohoe, Register.

We can also explore diseased women's experience inside the infirmary. When a woman arrived Cummings would "greet" her after she passed the gate keeper. The admission process has been covered above, suffice it to say that some diseased women played a role in self-diagnosis at the steward's interview, with some contesting the nature of their illness. Following the interview, she was formally recorded in the Admissions book by a clerk or junior medical attendant and by Cummings (or a later steward) in the Dockets. The actual medical exchange took place after her interview and was mostly one-sided on the physician's part. Mary Fissell has shown that by the middle of the eighteenth century, a common-ground in the between the doctor and poor patient eroded, and 'the relationship between lower class patients and their doctors was decisively changed'.⁷²⁷ The almshouse records do not make much reference to this aspect of the institutional experience. Siena suggests the effects of the 'birth of the clinical gaze' in Britain affected poorer hospital patients first. He also notes that this aspect of the medical exchange may have benefitted the pauper foul patient, given that he or she may have preferred to remain silent in a diagnosis concerning taboo areas of the body.⁷²⁸

Philadelphia Almshouse physician James Anderson left his journal from 1804, which points toward patient participation still being an important aspect of doctor-patient relationships.⁷²⁹ As we have seen, American doctors remained distrustful of the aspect of French observational medicine that objectified the body. Almshouse physician case files from the 1820s imply patients were still being provided with a platform to relate and interpret their medical history, which will become clear below. In any case, whatever agency a woman was able to display during the admission procedure with the steward generally ended when she stepped into the initial therapeutic phase of her almshouse experience. At this stage, it would be a safe assumption that a diseased woman played an insignificant role in negotiating the nature of medicine she would receive. It was only during her spell of therapy that she was able to shape her medical experience by absconding if and when she saw fit. Some women did leave on the

⁷²⁷ Mary Fissell, 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine', in Roger French and Andrew Wear (eds.), *British Medicine in the Age of Reform* (London: Routledge, 1991), 93.

⁷²⁸ Siena, *Venereal Disease*, 129.

⁷²⁹ See Appendix 3 for a discussion of Anderson's Casebook.

premise of her own diagnosis and also armed with an official discharge, thus one woman ‘decided she is cured and well’ and the physicians permitted her to leave the infirmary.

6.3 Sent to the Pennsylvania Hospital for Salivation

Establishing what a diseased woman actually experienced inside the polishing room is not a straightforward task, and the reconstructions below are dictated by limited and patchy sources.⁷³⁰ The almshouse managers and physicians rarely referred to methods of healing in the Minutes, nor did Cummings record such things in the Dockets. However, a small entry made in the Minutes proved it would be possible to learn more about this discovery by consulting the records of another hospital. In this overlooked reference to a list of venereal patients under the charge of the almshouse, the managers recorded that ‘the women...to be kept under Salivation...and to be removed here as soon as it can be done with safety’.⁷³¹ According to one nineteenth century almshouse physician it was,

...custom to have the venereal cases and violent insane treated at the Pennsylvania Hospital...In regard to the first, it was deemed necessary to, in accordance to medical notions current...to subject every case to a mercurial course, carried to the extent of salivation. In the Pennsylvania Hospital, the accommodations of this were greater and more complete than these at the almshouse.⁷³²

Hunter suggests that the more severe venereal cases were sent from the almshouse infirmary to the Pennsylvania Hospital where a fee would be paid or direct from the patient’s home by the Overseers.⁷³³ Moreover, an 1838 treatise recalled that, ‘Dr. Rush frequently employed salivation in mental diseases in the Pennsylvania Hospital’,

⁷³⁰ A study of a later period would provide for more fruitful analysis when case histories are more detailed.

⁷³¹ 18 Mar., 1786, M.M. After this date, the term ‘salivation’ does not appear again. I have trawled through the Managers and Physicians Minutes from the mid-1780s until the 1820s. In London hospitals, Siena finds that if foul patients were admitted requiring this medical procedure, they would always be noted as ‘in salivation’. Siena, *Venereal Disease*, 150.

⁷³² Agnew also states that in 1782 an Act was passed by the General Assembly ‘authorising the managers to bind out all persons treated for venereal disease until the expenses were liquidated from the product of their labour’. While there are indeed records of the managers binding out venereal patients, this seems to have been implemented in a haphazard way. Agnew, ‘Medical History’, 7.

⁷³³ Hunter, ‘Origins’, 40.

which attests to the fact that the procedure was customary in this institution.⁷³⁴ These references, together with various supporting sources, suggest that diseased almshouse women were not subjected to mercurial therapy as abrasive as that carried out elsewhere in the medical marketplace, particularly the Pennsylvania Hospital. This discussion will necessarily compare therapeutics between both hospitals.

Patient lists from the Managers Minutes of the Pennsylvania Hospital also confirm that almshouse patients were transported from the infirmary, including small numbers of venereal patients. Amongst the female patients sent from the infirmary were Mary Carlisle and Mary McCulloch.⁷³⁵ In 1793 Mary McCulloch was taken from the almshouse infirmary as a venereal patient and sent to the Hospital. However, by 1794 McCulloch was noted as being a 'lunatic' by the clerk recording admissions at the Pennsylvania Hospital. Mary was clearly suffering from tertiary syphilis, and the disease had progressed to the stage that attacks the brain.⁷³⁶ This substantiates Hunter's claim that only serious cases were transferred from the almshouse to the Pennsylvania Hospital. From a cross-examination of patients from both institutions it is evident that only those women suffering most acutely were transferred from the infirmary to the Hospital. This is also confirmed by the Managers' Minutes from the almshouse,

...those who are under the notice and charge of this institution [Philadelphia Almshouse]...most of whom are lunaticks...also John Rigg who hath a Venereal Complaint, it being a very Singular and Extraordinary Case and under a particular Treatment and is to remain there.⁷³⁷

The said hospital treatment appears to have been mercurial salivation. A thorough examination of the Pennsylvania Hospital Managers' Minutes reveals that the number of diseased women who were admitted from the almshouse was relatively low compared to overall numbers of almshouse venereal patients. Thus few women passed

⁷³⁴ John Eberle, Grigg and Elliot, *Treatise on the Practice of Medicine*, Vol. 1 (Philadelphia: Grigg & Elliot, 1835), 583.

⁷³⁵ The Pennsylvania Hospital is referred to as 'Hospital' for convenience and also because contemporaries did so. Mary McCulloch, Almshouse admissions: Feb. 1790, Mar. 1791, July, Sept. and Oct. 1792, Feb. 1793, Sep. 1794, Feb. 1796, Dockets.

⁷³⁶ June 1788, 27 April, 1793, 12 Feb. 1794. Pennsylvania Hospital Managers' Minutes hereafter cited as. Penn. M.M.

⁷³⁷ 2 April, 1788, M.M.

through the doors of both institutions.⁷³⁸ Therefore, even though patients *were* sent for salivation as Agnew suggested, it appears to be only the most acute cases. Moreover, both Carlisle and McCulloch may have endured treatments at the Hospital that may have cost them their lives. Both women displayed signs of acute mercury poisoning as we have seen from their medical histories. As in the case of Mary Carlisle, repeated mercurial salivations at the Pennsylvania Hospital may have contributed towards Mary McCulloch's 'highly pox'd' and 'shocking condition'.⁷³⁹

It is not clear when the practice of transferring diseased patients to the Hospital for salivation ended. During the 1780s local officials and the managers of both hospitals could not foresee Philadelphia's population explosion. And they certainly could not predict the severity of overcrowding, filth and hunger that accompanied mass immigration. As a consequence, endemic disease and a lack of institutional medical care meant the sick poor were scrambling for public relief. Even together, both institutions for the sick poor could simply not accommodate the numbers of venereal Philadelphians. From around 1788 it seems the practice of transferring patients was winding down. Referring to the 'sick paupers admitted as charity patients' into the Pennsylvania Hospital the almshouse managers pointed to the 'considerable additional expense at the charge of this House...which was not known before the Revolution'.⁷⁴⁰ Moreover, the Minutes from both institutions reveal ongoing tensions between both institutions' managers regarding payment for infirmary patients, and they came to loggerheads on several occasions.⁷⁴¹ The practice of sending venereal patients for salivation to the larger, more prestigious Pennsylvania Hospital seems to have ended at some point in the 1790s.⁷⁴² This was perhaps the result of changing medical opinions regarding the safety of mercury as well as financial constraints.

⁷³⁸ For an example of almshouse patients who were sent to the Pennsylvania Hospital for salivation, see, Catherine Smith, Sarah Campbell, Martha Barry, Mary Reed, 18 Mar. 1786, M.M., and Apr. 1786, Penn. M.M.

⁷³⁹ Mary McCulloch, Feb. 1796.

⁷⁴⁰ 8 Mar. 1786, 2 May, 1786, 12 May 1788. M.M. The sick patients sent from the almshouse tended to be insane cases. For a period in 1788 for instance, out of ten sick patients being treated as almshouse charity patients at the Pennsylvania Hospital, 'there are Seven Lunatic Persons...one with Epileptic Fitts...one with a Dropsy and One Venereal'. 12 May, 1788, M.M.

⁷⁴¹ For example, in 1790 the managers of the Hospital filed a law suit against the almshouse authorities, to 'recover a large sum of money which was owed by the City for the care of the sick poor and the almshouse authorities had to finally acknowledge the equity of the claim'. See Francis Randolph Packard, *Some Account of the Pennsylvania Hospital from 1751-1938* (Philadelphia: Engle Press, 1938), 5.

⁷⁴² I could only find one patient who 'came from the Hospital' to the infirmary. Nancy Holland, Dec. 1796, Dockets.

Furthermore, venereal patients were perceived as less interesting cases for medical investigations and experimentation in the Hospital. A case in 1796 is illustrative, suggesting that by this time the majority of diseased women were treated at the almshouse site. According to John Cummings

A case of many foul ulcers, a lame and helpless woman was recommended by Dr. Physick as a fit patient for the [Pennsylvania Hospital], but could not be admitted there under 22/6 per week, at the cost of this institution and our Doctors say she may be taken as good care of here and therefore need not be sent to the Hospital.⁷⁴³

By the closing years of the eighteenth century it seems this practice had ended. In a letter sent by the Almshouse managers to their counterparts at the Hospital regarding the transfer of patients, it was noted the former would, ‘cheerfully consent’ to remove ‘any three [curable] patients that the physicians of the Hospital select’. This was in addition to a number of patients recorded as lunatics. That the physicians of the Pennsylvania Hospital retained the privilege of selection suggests they would hand-pick those who would be useful for teaching and observational purposes. By 1802, the almshouse managers indicate that the only patients being transferred as charity cases to the Pennsylvania Hospital were solely those deemed ‘lunatic’.⁷⁴⁴

The almshouse infirmary did not cater to Hospital-style salivation. Mercury was not cheap, and salivation was a costly procedure.⁷⁴⁵ As Duffy notes, if calomel were employed on a sick person a prescription would need to be a high enough dose to encourage salivation.⁷⁴⁶ John Cummings noted how much of a liability Mary McCulloch was to the almshouse budget, describing her as ‘an expensive pauper not only in food and raiment but also in medicine and attendance of doctors who could be better employed’.⁷⁴⁷ As a consequence of her treatment in the Pennsylvania Hospital

⁷⁴³ 24 Nov, 1796. Dockets.

⁷⁴⁴ ‘Managers of House of Employment to Managers of Pennsylvania Hospital’, May 1799, PHA; 25 Jan. 1802, M.M.

⁷⁴⁵ Siena, *Venereal Disease*, 102-107. Siena points out that in London higher fees were charged for the process, and thus foul wards were the most costly in London Hospitals. Allannah Tomkins also alludes to this point briefly in her discussion on medical welfare in London workhouses. She notes that, ‘procedures requiring specialist knowledge or equipment could be provided but these were one-off instances; for example...St. Mary paid £1 for William Cooke to be salivated for the pox’. Allannah Tomkins, *The Experience of Urban Poverty, 1732-82: Parish, Charity and Credit* (Manchester: University of Manchester, 2006), 123. Unfortunately Tomkins does not entertain detailed discussion on therapeutic practices and medicines.

⁷⁴⁶ Duffy, *Humors*, 71.

⁷⁴⁷ Mary McCulloch, Mar., 1793, Dockets.

she managed to clock up a huge bill in medical expenses.⁷⁴⁸ Even though the almshouse played a crucial role as the city's chief receptacle for sick paupers, it simply did not have the resources to provide advanced therapeutics, and thus the same range of medical care offered at the Pennsylvania Hospital. The issue of purchasing cheaper medicines was a constant source of friction between the physicians and managers. This reached a head in 1808 when the managers appointed a 'Committee on Drugs' to 'enquire whether the drugs & medicines in this House can be procured on more reasonable terms'.⁷⁴⁹ Moreover, economic considerations prevailed over moral concerns amongst management, and thus often dictated therapeutic practice in American hospitals.⁷⁵⁰ Almshouse physician James Anderson's casebook illuminates the difference in one doctor's practice between treatment of his private customers and treatment of his infirmary patients. During his private calls in Chester County, Anderson was more liberal in administering mercury or other compounds than was the case during his ward rounds in the almshouse.⁷⁵¹

Salivation needed further ingredients beside the drug itself. Medical literature at the time placed a great deal of emphasis on heat and sweating for a course of therapy to be effective.⁷⁵² External heat was necessary for patients undergoing various salivation or fumigations procedures, obviously easier for the wealthy to attain. In the domestic setting a patient could be salivated in his or her own bedroom, with coals and wood constantly burning in the hearth. The fundamental requirement for a successful salivation was for the patient to be kept as warm as possible, yet how could this be achieved in an institution constantly in short supply of fuel. The almshouse Minutes pertaining to items purchased for the institution show no indication that the venereal wards needed the extra coals that would be required for such a procedure.⁷⁵³

⁷⁴⁸ That her bill included expenses for new flannels also suggests she was under salivation in the Pennsylvania Hospital given that after the procedure a patient would be ordered to change into new linens to eradicate any remaining traces of foul infection.

⁷⁴⁹ 8 Feb. 1808, M.M. Also see 4 Jan, 1808, 12 Dec., 1808. M.M.

⁷⁵⁰ Rosenberg, *Care of Strangers*, 54-5.

⁷⁵¹ James Anderson, 'Notes taken by the Author from his Country Practice, Charlestonship, Chester County', 1806. HSP.

⁷⁵² Temkin, 'Therapeutic Trends', 314.

⁷⁵³ In fact, the almshouse infirmary and house of employment frequently suffered from want of coals and wood for fuel. The requirements of the medical department were routinely sent to the managers.

In addition to salivation, Hunter states that ‘venereal patients were sent to the Pennsylvania Hospital for special treatment with mercurial vapour’. Expenditure on coals and wood in this institution far surpassed that of almshouse consumption.⁷⁵⁴ Mercurial vapour was especially deadly, and fumigation by vapour also needed fuel, with cinnabar (red mercury ore) thrown onto coals to generate fumes, with the patient sweating out the toxins. Particularly notable by its presence in the apothecary store of the Pennsylvania Hospital is cinnabar. In 1798 Nathaniel Chapman attended a lecture as a student, given by Dr. Barton. During his lecture on the uses of mercury Barton stated, ‘by the fumigation of mercury...Dr. Rush...produced ptyalism⁷⁵⁵ in 3 hours by the Fumes of Cinnabar’.⁷⁵⁶ Both Barton and Rush practiced in the Pennsylvania Hospital at this time. Only a few years later, Chapman -as almshouse physician- would discard the procedure as downright dangerous. An additional vapour procedure employed on venereal patients was by placing the patient in a steam bath.⁷⁵⁷ The mercury would combine with steam to create a highly toxic vapour, and patients in the Pennsylvania Hospital may have been subjected to this (patient case files of other illnesses note the use of hot baths). However, it is evident that at the almshouse, venereal patients were not subjected to the toxic fumes produced by vapour baths. The physicians frequently requested baths simply for washing their patients, thus the provision of baths for therapeutic procedures would simply be asking too much of the Managers.

Salivation required confinement indoors and also separation from other patients. The polishing room was not restricted to venereal patients, and often inmates suffering

⁷⁵⁴ Hunter, *Origins*, 44. For a comparison of expenditure see Pennsylvania Hospital Board of Managers Minutes, 12 May 1794; 5 May 1804 and 14 May 1804; 4 May 1833; Guardians of the Poor Philadelphia Almshouse Managers Minutes, 1788-1828 and Treasurers Weekly Entries, 1791-1822. According to Clement, almshouse officials had to adhere to a strict fuel budget, and prices often escalated sharply, particularly during the harsh winters. Clement, *Welfare and the Poor*, 29. This was particularly exacerbated by a sharp hike in fuel prices Philadelphia during the 1810s. Mathew Warner Osborn, ‘A Detestable Shrine: Alcohol Abuse in Antebellum Philadelphia’, *Journal of the Early Republic*, Vol. 29, No. 1 (2009), 104.

⁷⁵⁵ Salivation.

⁷⁵⁶ Nathaniel Chapman, ‘Notes from Dr. Barton’s Lectures’. Nearly twenty years later Barton would reiterate this procedure as being ‘very useful in healing...venereal ulcers’, although he did note that ‘Dr. Cullen says this practice is attended to with some hazard’. Mitchell, ‘Lecture Notes’, 22 Feb. 1816.

⁷⁵⁷ A vapour bath needed steam from boiling water that would be passed through pipes to circulate around the patient. David Dymond, *Stutter’s Casebook: A Junior Hospital Doctor, 1839-1841* (Woodbridge: Suffolk Records Society, 2005), 126.

from a variety of ills took up beds in this ward.⁷⁵⁸ Moreover, the medical and surgical wards received diseased women and thus venereal and non-venereal patients were often mixed in the same wards. It would have been impossible to salivate a patient in such an environment, because the accompanying fumes or vapour would affect other patients. The layout of the almshouse was plainly not conducive for the specialised medical procedure, given that cramped conditions would impede any possibility of isolated treatment. The physicians continually complained about overcrowding. The Minutes never suggest that venereal patients needed a specific type of treatment, rather, the ward was rendered ‘too small for the sheer number of persons who occupy it’. Thus, the medical team requested larger accommodation.⁷⁵⁹ In 1812, the physicians requested ‘four hundred dollars’ for ‘converting the venereal ward into cells in which case the patients of that ward might be removed into a comfortable and suitable apartment’.⁷⁶⁰ To the modern reader this could appear suggestive of an attempt to enforce moral correction if it were not for the presence of the term ‘comfortable’. It may be that the doctors simply wanted to have the option to salivate patients (this could have been with any compound not strictly mercury, usually guaiacum). It is not clear if this was the case. What is certainly evident from the nature of this request is the suggestion that venereal patients would be better situated in ‘compartments’, thereby illustrating that the infirmary wards had never been equipped to salivate patients.

What’s more, the use of mercurial drugs carried to the extent of salivation had become extremely unpopular among many almshouse physicians, as argued in chapter five. Even if the accommodation had been suitable for this highly toxic procedure, it would have been unlikely that almshouse doctors would have practised it. Almshouse physicians submitted patients to alternative and gentler therapeutic strategies, based on the presumption that venereal infection could be cured without the use of mercury, even in small doses. Therefore, a combination of therapeutic consensus and cost effectiveness dictated a diseased woman’s medical regimen in the almshouse.

⁷⁵⁸ The designated ‘venereal wards’ often referred to in the Minutes also attests to the fact that proportionately, venereal patients comprised the single largest group of sick patients in the infirmary because they had their own designated ward.

⁷⁵⁹ 22 Dec. 1815. Also see, 20 July, 1812, 9 April, 1813, M.M.

⁷⁶⁰ 13 Sep. 1812, M.M.

6.4 Samuel Duffield's Drug List and the Almshouse Apothecary Store

Ironically, there is more chance that wealthier syphilitics were exposed to greater mercurial poisoning given that they could afford such treatments. So far it appears conditions in the wards of Pennsylvania Hospital were ripe for abrasive treatment, unlike the almshouse polishing room. To be sure the Hospital did not always resort to mercury, and also employed alternative minerals or plant-based medicines. The apothecaries from both institutions ordered barks, roots and woods in large quantities; the key difference was that the Pennsylvania Hospital could place an order for the 'best Peruvian Bark'.⁷⁶¹ To support this theory, we can examine the almshouse apothecary store to explore the range of medicines kept on its shelves.

In April 1785 Samuel Duffield went on a shopping mission to purchase a chest of medicines from the apothecary store of 'Sharp & Delaney' on Second Street near Walnut. The druggist provided Duffield with a receipt for his purchase, which now lies in the Historical Society of Pennsylvania. The apothecary's receipt does not confirm whether the drugs furnished to Duffield were for his hospital or private practice, however, the evidence indicates that the doctor intended to supply the almshouse with the medicines.⁷⁶² Duffield's previous connection as a partner with Delaney would also suggest he was sold medicines at discount prices.⁷⁶³

The drug list contains the usual equipment a doctor would need: bottles, ground stoppers, pots and vials. Other dominant items include the narcotics camphor and opium; the potassium-based cream of tartar and the antimonial tartar emetic, both used for purging.⁷⁶⁴ What is particularly revealing about Duffield's choice of drugs is the significant presence of plant-based compounds, including four ounces ipecac,

⁷⁶¹ 25 April, 1785, Penn. M.M.

⁷⁶² See Appendix 1 for a copy and transcription of the list. Samuel Duffield, 'Receipt Received June 9th 1785, Sharp & Delaney', HSP. Sharp and Delaney are noted in the Minute's as one of the providers for the infirmary's apothecary shop, and as Agnew states, Duffield was one of two physicians 'required to become the purchasers of all drugs consumed by the sick' Agnew, 'Medical History', 8.

⁷⁶³ Ibid., 7. Duffield was a partner in the firm until 1775, when Duffield & Delaney dissolved and Sharp joined. Duffield became a permanent physician to the almshouse in 1772, and it is likely he left the partnership to concentrate his efforts on attending to the sick poor. Randolph Shipley Klein, 'Class of 68: Graduates of America's First Medical School', in Randolph S. Klein (ed.), *Science and Society in Early America: Essays in Honor of Whitfield J. Bell, Jr.* (Philadelphia: American Philosophical Society, 1986), 122.

⁷⁶⁴ See appendix 2 for more detailed descriptions of all drugs mentioned, and definitions of pharmaceutical terms. Calomel is also on the list although the quantity is illegible.

considered especially useful as a purgative (it is still used to counter the effects of poisoning). The largest quantity of any drug purchased was a, “lb cinchona bark” (Peruvian bark).⁷⁶⁵ Further vegetable and plant based medicines on the list include camomile flowers, bascilion ointments and the popular cathartics rhubarb, jalap, and a ‘bottle...ol ricini’ (castor oil). Therefore, a central feature of Dr. Duffield’s choice of drugs is botanical and vegetable articles commonly associated with contemporary treatment of venereal diseases.

To build a more comprehensive picture of almshouse medicines we can turn to an inventory held by the medical department, which reveals the orders placed for a one-year period from 1810.⁷⁶⁶ During this time an astonishing amount of botanical medicines were requested by the apothecary, including various barks and roots commonly used by contemporaries to treat gonorrhoea and syphilis. One of the largest quantity of any medicine purchased was Sarsaparilla, by now long-touted as a specific for syphilis. Ellis’s *Medical Formulary* (inspired by Chapman) noted the plant as ‘particularly serviceable in secondary forms of syphilis, and in syphilitic rheumatism’.⁷⁶⁷ The most notable compounds ordered were: 29 lb Columba Root; 40 lb sarsaparilla; 34 lb liquorice root; 29 lb copaiba and 20lb sassafras.⁷⁶⁸ Other ingredients frequently secured by the apothecaries were guaiacum and hemlock (venereal specifics); alum root; juniper berries; rose petals; myrrh; nutmeg; red Seneca; sage and honey, not to mention the plentiful weekly order of Peruvian bark and opium.⁷⁶⁹ Large quantities of ‘common caustic’ were also ordered, which were typically applied locally to destroy venereal sores. Compounds used to make blistering plasters including mustard seeds and beeswax were also logged. These would no doubt be used as an alternative to mercurial blisters. Mercury was also listed

⁷⁶⁵ According to Rothstein, cinchona bark was beginning to assume an important role in therapy during our period, although it would become most notable in the late nineteenth century. William Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: John Hopkins University Press, 1972), 28-29, 53; Opium and cinchona were also well-known to curb the disastrous effects of mercury, and they were often used together as a sedative or for pain relief. Historians refer to both as the, ‘aspirins of the day’. See, Ronald V. Loge, ‘Two Dozes of Bark and Opium: Lewis and Clark as Physicians’, in, eds. Kris Fresonke and Mark David Spence (eds.), *Lewis and Clark: Legacies, Memories and New Perspectives* (Berkeley: University of California Press, 2004), 71.

⁷⁶⁶ 4 May, 1810, P.M.

⁷⁶⁷ Ellis, *Medical Formulary*, 205.

⁷⁶⁸ P.M. 1810-1811. I have used the ‘lb’ abbreviation for the sake of simplicity and because this is how the weights of drugs were noted.

⁷⁶⁹ The surgical casebook outlined below illustrates that all of the above were used frequently on female venereal patients.

in its various forms including: 5 lb calomel; 8 lb quicksilver;⁷⁷⁰ 6 lb corrosive sublimate, and ‘5 lb mercurial precip. Rub’.⁷⁷¹

During the first two decades of the nineteenth century, Peruvian bark and sarsaparilla in particular remained highly popular.⁷⁷² During the 1820s plant-based ingredients such as sarsaparilla, copaiba, Peruvian bark and cicuta continued to be ordered frequently. During a two-month period from November 1825, the ‘List of articles wanted by the Medical Department’ contained 150 lb ‘red sarsaparilla’, ‘8 oz pith of sassafras’ and ‘50 lb Balsam of Copaiba’. Nitrous powders, potassium, magnesium, lead, and sulphur were also ordered, although minerals and acids were ordered in lesser quantities than the woods and barks. Moreover, only ‘3 lb hydrygyriari’ (blue pill mass) was ordered during the same period.⁷⁷³ For the entire year (1825-1826) only 12 lb calomel was purchased to be compounded by the apothecaries. An additional feature of the medical lists worthy of note is that the almshouse apothecaries and physicians trusted patent remedies, and ordered medicines such as ‘Dr. Anderson’s Pills’, the base-compound being aloe. This confirms that like Duffield and Chapman, their associates appear to have been open-minded about irregular nostrums.

The overall impression gained from the above evidence is that almshouse patients were frequently dispensed with drugs and medicines compounded from plant based ingredients. It could be argued that some botanical ingredients carried the double-edged sword of being poisonous given in large doses. However for reasons of expenditure, it is a safe assumption that almshouse patients were treated with weaker and relatively milder remedies.

⁷⁷⁰ For quicksilver to produce any significant effect noted almshouse doctor James Anderson during a lecture by Benjamin Barton, it had to be ‘exhibited in large quantities’, and only if employed for a length of time, was it capable of ‘inducing salivation’. Anderson, ‘Barton’s Lectures’.

⁷⁷¹ P.M., 1810-1811.

⁷⁷² European doctors often referred to the plant as ‘American Sarsaparilla’ indicating they had imported the root thereby making it an expensive remedy. Its high cost in Britain also suggests it was highly sought after because it was known for its benefits in aiding the cure of venereal infections. The English physician William Acton could complain of ‘a long and expensive course of sarsaparilla’ while Americans could easily procure it given the widespread availability of the herb in the southern regions of North America. William Acton, *A Treatise on Diseases of the Urinary and Generative Organs in both Sexes* (London: John Churchill, 1860), 368. Also see Michael Castleman, *New Healing Herbs: The Classic Guide to Nature’s Best Medicines*, (Emmaus, PA: Rodale Books, 2001), 359-61.

⁷⁷³ Nov. 1825, Jan 1826, M.M.

To test this theory further, a comparison of cost accounts between apothecary shops at both institutions adds weight to the argument that therapy at the almshouse was less abrasive than at the Pennsylvania Hospital. In 1820 the managers of the Pennsylvania Hospital launched an investigation into the apparent frivolity of their apothecaries. Consequently, a ‘laborious and minute examination...of the accounts furnished by druggist C. Marshall’ was undertaken. As a result, it was revealed that the amount spent by the apothecaries for 1817 totalled \$731. Yet by 1819 there was an astonishing hike in the bill, which amounted to \$1165.⁷⁷⁴ That the apothecaries were seemingly squandering resources by purchasing above and beyond ‘capital medicines’ prompted the managers to investigate further. Their intent was to ‘enquire what quantity’ of medicines and related medical and surgical sundries were ‘consumed in the Alms House’. This would allow them to compare costs proportionately between both institutions. The Managers were shocked to discover, that despite the greater number of patients being medically treated at the almshouse, drug costs were proportionately and considerably higher at the Pennsylvania Hospital.⁷⁷⁵ The managers blamed the resident physicians, apothecaries and their respective apprentices for over-indulging their patients with medicines.⁷⁷⁶ By contrast the almshouse records reveal a different story. Drugs compounded in the apothecary store of the infirmary were ‘diluted’ in an effort to meet the financial targets demanded by the managers.⁷⁷⁷

An incident occurring at the almshouse in 1803 confirms that the Pennsylvania Hospital utilised a proportionately greater quantity of (and probably costlier) drugs than the almshouse. A matter arose concerning the actions of a senior pupil while he was on duty at the almshouse, and subsequently a ‘number of distinguished physicians were requested by the Board to investigate’. Lawrence’s account of the incident is worth quoting in full.

Their [physicians] report said: “A complaint of a very serious nature, at your last meeting, been charged before you against one of the present attending physicians, and

⁷⁷⁴ 20 Feb. 1820, Penn. M.M.

⁷⁷⁵ Ibid.

⁷⁷⁶ This problem continued in the Pennsylvania Hospital. In 1825, the managers attempted to enforce a ‘better system to prevent wilful or careless waste of medicines’. 21 Nov. 1825, Penn. M.M.

⁷⁷⁷ For instances of the almshouse managers tightening the budget on drugs, see 27 Feb. 1809, 8 June 1812, 16 June 1817 and 11 Apr. 1826, M.M.

by you referred to our judgement, we have, without delay, carefully enquired into the circumstances. They are succinctly these: Dr James, the physician complained of, prescribed camphor in small doses of ten or fifteen grains for Savage, a maniac, leaving a choice of either quantity to the discretion of the senior pupil, Dr. Scott. The medicine was made up in the form of a mixture, but the portion given at each dose amounted to about thirty grains. This error is not attributable to Dr. James, whose conduct was cautious and correct.” The matter too, was in itself harmless, this patient, while in the Pennsylvania Hospital having been in the habit of taking quantities of a much more considerable amount.⁷⁷⁸

This last remark is telling. The patient had had become immune to his medications in light of the harsher doses dispensed to him while he was a patient at the Pennsylvania Hospital. This lays more credence to the contention that therapeutics at the almshouse were not of an abrasive nature. (The consequence of this pupil’s mistake has benefitted the historian because prescriptions were formally recorded from this date, although most have not survived). At a subsequent meeting the managers declared,

It is our duty to state our apprehensions that much worse mistakes occur...In order that they may in the future be obviated, we beg to propose that the senior pupils should enter into a book an accurate account of the symptoms with each patient affected, and a regular register of medical treatment...The measure here is not new or unprecedented; it is practised in all the hospitals in Europe...and would form a collection of medical facts of high value.⁷⁷⁹

Physicians practicing in the Pennsylvania Hospital did acknowledge the tendency of this institution to practice heroic-style medicine, and one doctor seems dubious about the prevalent use of mercury. Following a successfully cured case of ‘Phlegmonous Erysipelas’, Dr. Elmer remarked that ‘the inflammation had run its course & was in this respect *uninfluenced* by the Mercury which had been administered’.⁷⁸⁰ The doctor therefore suspected that Mother Nature called at the patient’s bedside. A point worth emphasising is that doctors’ opinions on therapeutics varied, often widely, as was highlighted by Drs. Rush and Kuhn who stood poles apart in their treatments of yellow fever. The following case in the Pennsylvania Hospital illustrates one doctor’s preference to natural remedies over another. A patient was admitted to the Pennsylvania Hospital in 1784 with swellings on his abdomen and his extremities. Subsequently, ‘Dr. Kuhn confirmed it as a case of scrofula & prescribed the extract of

⁷⁷⁸ Lawrence, *History of the Philadelphia Almshouse*, 46-8.

⁷⁷⁹ Ibid.

⁷⁸⁰ Collection of Hospital Cases, Vol. 1, 1803, PHA.

hemlock- a vegetable diet with milk [with] a decoction of the Woods'. This treatment was continued, and although the medicine 'made him sick at the stomach', the patient nevertheless 'grew better'. However at this juncture Dr. Rush came on duty, and 'ordered the cicutta to be omitted'. In its place, Rush prescribed the following treatment to 'be applied to every part of the body at night': corrosive sublimate to be followed the next day with a mixture made from an ounce of calomel, also with a vapour bath. The patient relapsed after Rush's regimen was put in place. Yet, the mercurial course was followed in the form of pills, which 'induced a ptyalism (salivation) and a few days later, death followed'.⁷⁸¹ Thus we see Kuhn's milder plan being thwarted by Rush who implemented a "cure" which in fact seems to have killed the patient. It is unlikely this kind of mercury poisoning occurred during therapy at the almshouse unless the patient had recourse to mercury prior to admission.

6.5 The Polishing Room

Apothecary's Ledger, 1804.

A surviving record that contributes towards a partial reconstruction of almshouse venereal medicines is the 1804 Apothecary's Ledger, although it is patchy and often illegible.⁷⁸² There is enough information on Susannah Morgan to create a picture of medicines. Susannah was entered in the Ledger in January 1804 although her illness is not stated, yet she first appears in the Dockets in 1798 as venereal. By 1800 Susannah was 'an old polishing room customer...now with sores and a sore throat'.⁷⁸³ It would be a reasonable assumption that Susanna was suffering quite severely from secondary syphilis. On her first day in the ward the doctor sprinkled Cream of Tarter⁷⁸⁴ over her sores. Throughout her five-month stay Susannah was prescribed opium pills every three or four days made from two grains.⁷⁸⁵ At a later date a powder made from magnesium salts was applied to her sores, and she was also dosed with herbal

⁷⁸¹ William Martin, 'Prescriptions of Cases in the Pennsylvania Hospital', HSP.

⁷⁸² Apothecary's Ledger, Cost per Inmate, 1804-1806, PCA. In this source the patient's name and a daily breakdown of medicines is provided. Although the nature of a patient's illness is not confirmed, a cross-examination with admission registers helps assess who was being treated for venereal diseases.

⁷⁸³ Susannah Morgan, Admitted: Nov. 1798, Dec. 1800, Feb 1802, Jan. 1804, Sep. 1804; Discharged: May 1801, April 1803, May, 1804; Died: Aug. 1805, Dockets. It seems likely some discharges have not been accounted for. She was recorded on the relevant dates in the Weekly Return of Patients; the Apothecaries Register, 1800-1803 and Admissions and Discharges.

⁷⁸⁴ See appendix 2 for a description of all medicines mentioned.

⁷⁸⁵ We should recall from chapter five that Chapman recommended 'solutions of narcotic articles or sole solutions of opium' for secondary syphilis.

tinctures made from solutions of guaiacum. It is impossible to deduce whether mercury had been used in the almshouse prior to her 1804 admission, or indeed if Susannah had recourse to mercury elsewhere although it is certainly feasible. Nonetheless, during this admission she was not prescribed mercury in any form and she was discharged in May. By September 1804 when she returned she was deemed ‘incurable’, which may account for the continual use of opium. It is likely Susannah experienced substantial pain and she died during a later admission in 1805. Mary Smith was admitted to the venereal ward the same week as Susannah in January 1804.⁷⁸⁶ Mary was also a habitual patient and appears to have suffered from secondary syphilis, although she was not as far gone as Susannah because she was still capable of eloping. She was nevertheless in a great deal of pain because on her first day in the ward she was given a pill made from ten grains of opium, which she took with two gills of brandy. The opium was continued with no change in medication until two weeks later, when she was given ‘a dose of calomel and jalap’.⁷⁸⁷ During the following month Mary was dosed frequently with wine, brandy and opium, and no further mercury was prescribed. Therefore, although Mary was prescribed mercury it was not until her second week inside the ward, and it was a relatively weak and singular dose.⁷⁸⁸

A similar pattern of cures is discernable in other diseased women and Rachel Harris’s case exemplifies many others. Rachel was admitted while Mary and Susannah were both occupying beds in the ward. She was prescribed with tinctures made from guaiacum bark, and she was also given Dovers Powder (ipecac bark, opium and liquorice).⁷⁸⁹ Caustic applications made from vitriol were applied her sores at periodic intervals. Rachel was dosed liberally with opium throughout her stay and she was not given any mercury during this spell of treatment. However, after being discharged

⁷⁸⁶ The almshouse doctors and apothecaries referred to the “venereal ward” as opposed to the “polishing room”.

⁷⁸⁷ The record does not pertain to the actual number of grains of calomel, but the cost of this was 6 cents, which in comparison to doses of calomel prescribed to other patients is suggestive of three grains. According to Swiderski, a ‘five- or three-grain pill’ of calomel was a mild dose. Richard Swiderski, *Quicksilver, A History of the Use, Lore and Effects of Mecerury* (North Carolina, McFarland & Company, 2008), 127.

⁷⁸⁸ On this occasion Mary was ‘discharged cured’ although she died the following year. Mary Smith, Jan. 1804, Apothecaries Ledger, 28 May 1802, Weekly Return of Patients; Mar. 1798, Feb. 1805, Dockets.

⁷⁸⁹ Dovers Powders had its origins in the seventeenth century. Dover’s critics accused him of merely imitating Thomas Sydenham for his public opposition to the use of mercury treatment in venereal disease. Swiderski, *Quicksilver*, 22.

after two months in March, she returned in April. This time Rachel was ordered to take the blue pill made from one grain of mercury.⁷⁹⁰

Although there are some instances when women were given mercury on their first day, the strength appears to have been relatively small, although the nature of the source does render this inconclusive. After a cross examination with related registers, in such cases it would appear these women were suffering from secondary syphilis. For the majority of diseased patients acidic or metallic solutions were always accompanied with, or preceded by herbal mixtures. Catherine Drake's therapeutic plan is notable for its typicality. Drake was entered in the Ledger in January 1804 and related registers confirm her syphilitic.⁷⁹¹ During her first day in the ward she was given a decoction made from six drachms sage, with a pill made from ten grains of opium.⁷⁹² The following day Catherine's ulcers were rubbed with mercury ointment, accompanied by a tincture of myrrh. For the month of March, she was prescribed brandy, wine and myrrh, in addition to decoctions 'of the woods', including camphor, Peruvian bark and guaiacum. Between her admission into the ward in January and her discharge in July, Catherine Drake was prescribed with mercury on three further occasions only (once as four grains calomel, and twice again in unction form).

The above patient files are revealing for several reasons. First, the physicians routinely tried various compounds -mostly natural in origin- and persevered with different combinations until the patient was relieved. Second, treatment plans were clearly established ad hoc by physicians' observational methods. Thus, therapy was based on trial and error judgments as opposed to the oft-believed notion that mercury was given as a specific and blanket remedy. Catherine Drake's case is illustrative of a woman suffering from syphilis. When mercury *was* prescribed it was usually after, or alongside the employment of botanical remedies. Furthermore, opium was clearly a favourite of the medical team and it was prescribed liberally and indiscriminately. Unfortunately the Apothecary's Ledger was kept as a rough account book recording costs for patients suffering from a variety of ailments, and only occasionally reveals the actual strength of mercury dispensed. Moreover, the apothecaries were haphazard

⁷⁹⁰ Rachel Harris, Jan and Apr., 1804, Ledger.

⁷⁹¹ Catherine Drake, Admissions, Jan. 1804, Oct. 1804, Discharge, July, 1804. Dockets, Weekly Returns.

⁷⁹² The apothecary measurement for one drachm is sixty grains.

in recording information and mostly seem to note patients who were treated over a lengthy period, suggestive that women were in advanced stages of venereal disease.

Medical and Surgical Case Records, 1816-1817

A source providing richer data is the medical and surgical case records, which contained in two volumes, reveal a more established pattern of therapy. Moreover, they are more precise with diagnosis and therapeutic regimen than the Apothecary's Ledger. However they lack details more characteristic of later patient case files, which often include the doctor's interpretations of symptoms, reason's for therapy and step-by-step treatment plans. Nonetheless, the case records do contribute toward a more revealing picture of diseased women's medicine. The two casebooks were kept from 1815 to 1817 and we can explore the therapeutic methods employed through different stages of disease.

When twenty-year-old Mary Berry was admitted in 1816 with a gonorrhoeal ulcer she was treated with fifty drops of Balsam Copaiba, which she was ordered to take daily with brandy. Mary eloped after a few weeks of treatment. This was her first trip to the infirmary and she did not return. Sarah Davidson was admitted with the same symptoms, and also prescribed with Copaiba, along with opium and a caustic solution of lead acetate to apply to her wart. Like Mary, Sarah never returned to the almshouse after being patched up. It is likely both women were aware of almshouse protocol through hearsay and ultimately sought a mild, quick-fix solution, which they indeed received. Some women were suffering from gonorrhoeal afflictions of a more chronic nature.⁷⁹³ Rebecca Thompson was admitted on 18 January 1817. When she arrived in the venereal ward the attending physician applied a 'caustic solution of acetate of lead to [the] wart', with a teaspoon-full of iodine. No other medication was given to Rebecca until eight days later, when the doctor prescribed Elixir of Vitriol tonic. She remained in the ward for two weeks, being dosed daily with Balsam of Copaiba, after which she was 'discharged cured'. Eliza Smith was admitted the following month with a similar, probably minor ulcer and she was simply treated with thirty drops of

⁷⁹³ Mary Berry, 19 June, 1816, Guardians of the Poor, Philadelphia Almshouse Hospital Surgical and Medical Ward Case Records, 1816, PCA; Census and Admissions, 1816.

Balsam Copaiba and alcohol for her entire stay.⁷⁹⁴ So far, it would seem Chapman's proposals to employ the use of Balsam of Copaiba for gonorrhoea was adhered to in the venereal ward.

Some women were taken in with symptoms appearing gonorrhoeal only to find later they were syphilitic. When Charlotte Hayes arrived at the ward in 1816 she was given Balsam of Copaiba along with a gill of brandy. The doctor in charge ordered her to take this treatment daily. Two nights later Charlotte's symptoms were causing her significant pain and she was unable to sleep. She was given opium pills and directed to continue this every night, along with her daily medication of Copaiba drops and brandy.⁷⁹⁵ The following week Charlotte's symptoms had yet to disappear, and she was ordered to take blue vitriol solution for a week in small doses. By the end of May her ulcers resembled buboes, now more symptomatic of syphilis than gonorrhoea. The doctor then ordered a caustic solution of lead acetate to apply to her sores, and for the next three weeks she was dosed with opium and brandy as her only medications. By the third week of June the surgeon was clearly worried about her condition, and prescribed her with mercurial ointment to 'dress the sores'. This did not work and Rebecca's condition worsened, and five weeks after being admitted she was purged with calomel and jalap.⁷⁹⁶

Confirmed cases of syphilis appear to have been treated with a standard pattern of therapy. Some of the diseased women in the 1816 casebook were former customers returning in advanced stages of disease. Eighteen-year-old Mary Currie was admitted in 1816 and admission lists confirm it was not her first time. Her treatment plan was as follows. On 30 May, Mary was given a rub made from one teaspoon of mercury ointment. Two days later this was discontinued and she was dosed with a simple decoction made from the leaves of uva ursi (bearberry) with a grain of opium every

⁷⁹⁴ Rebecca Thompson and Eliza Smith, *Guardians of the Poor, Almshouse Hospital Surgical Ward Case Records, Jan 1817- July 1817*.

⁷⁹⁵ Chapman's associate, Ellis recommended this injection as 'an efficacious mode of treating gonorrhoea'. Ellis, *Formulary*, p.263.

⁷⁹⁶ Charlotte Hayes, May 1816, *Case Records*. It is likely many women suffering from stubborn gonorrhoeal ulcers like Rebecca were given a pill described in Ellis's handbook. This was compounded from a mix of 'Copaiba & Calomel taken morning and evening...employed in long-continued gonorrhoea'. Ellis, *Medical Formulary*, 75.

night.⁷⁹⁷ She left the infirmary ‘cured’ after a one-month spell of treatment.⁷⁹⁸ Hannah Smith was admitted to the ward while Mary was undergoing treatment, and she seems to have been familiar with the routine. Related registers confirm the twenty-one year-old was treated in the same ward eight months prior to this admission, then also being a ‘former patient’. After a brief course of medicine in 1815 she eloped after receiving the medical care she sought. During this later spell of treatment in 1816 Hannah was treated to a ‘Gill of Brandy’ daily and two drops of white vitriol. This was accompanied by a daily decoction made with four ounces of Peruvian bark to use as a gargle.⁷⁹⁹ No sign of any mercury for Hannah, who left the venereal ward two weeks after her arrival, and this time with a formal discharge.⁸⁰⁰

As outlined in chapter three, many women only used the almshouse once for syphilis treatment. When seventeen year-old Ann Pointer was admitted it was her first time in the infirmary. Her only medication was a drink made from sarsaparilla, and potassium of iodide to ‘rub to [the] eruption’, which was accompanied by wine. She was ‘discharged cured’ the following week. Perhaps Ann was an acquaintance of Maria Dannel. Both women were Southwark residents, and they may have heard through their associates what kind of treatment they were likely to receive if they went to the almshouse. Maria arrived the day after Ann left. She was diagnosed with syphilis and prescribed with a mixture of myrrh and water as a gargle, and opium mixed with olive oil every night. She stayed in the infirmary for three weeks before returning to her daily business.⁸⁰¹ Neither women were given mercury, and neither returned

Of course there were women who *were* treated with mercury. Mary Maybird was admitted with a chancre and given a pill made from calomel (one grain) as well as opium and brandy. Martha Miller suffered from secondary syphilis and spent three weeks in the venereal ward. In that time she was given Colombo root infusion daily, thirty drops daily of copaiba, and a powder of vitriol. Mercury was not resorted to

⁷⁹⁷ Recall, this was recommended by Chapman, who claimed, ‘the uva ursi...a far better remedy...more than once I have cured this complaint by this alone’, ‘Chapman’s Notes’, Vol. 2.

⁷⁹⁸ Mary Currie returned several times over the next couple of years that can be deduced from the Weekly Census records. 30 May to 13 June 1816, Case Records, May 1816, 8 June 1818, Weekly Census.

⁷⁹⁹ By now we can see Peruvian bark (also labelled Jesuits bark, cinchona) was an almshouse staple.

⁸⁰⁰ Hannah Smith, 17 Oct. 1815, Weekly Census, 28 May to 13 June 1816, Case Notes.

⁸⁰¹ Anne Pointer 30 May to 5 June 1816, Case Notes; Maria Dannel, 5 June to 30 June 1816, Case Notes. Their residency is confirmed in the Dockets and Weekly Census and Admissions.

until ten days into her stay, when one teaspoon of ointment was given 'to rub' daily. Significantly Martha left a week later with an official discharge of 'cured', which simply was not have been enough time to induce or maintain a salivation. Conversely Rachel Wilkins was given a mercury pill on her first day in the ward, which was made from one grain and recommended to be taken 'every other day'. She was also given the herbals copaiba and Ipecac.⁸⁰²

We regularly find therapeutic practice proposed by almshouse doctors like Chapman outlined in chapter five. Maria Coffee was admitted with 'syphilis' and her treatment plan consisted of cicuta as 'simple dressings' applied to her sores, accompanied by sarsaparilla, brandy and a Lisbon diet drink. No mercury was administered and Maria never returned to the almshouse. Maria's therapy is very similar to that carried out on a patient by Chapman's mentor Dr. Carmichael. His patient Martha Lloyd was presented to Carmichael with 'ulcers...scattered over her body'. She had also been exposed to mercury prior to her consultation with Carmichael. According to Carmichael, Martha was 'evidently affected by the mercury' from this prior treatment, and the 'great extent of ulcerated surface so harassed a debilitated and broken down constitution that she did not survive'. Carmichael observed that 'if Martha had continued on the use of sarsaparilla combined with opium or cicuta in doses sufficient, and if mercury had not been employed, she would have recovered'.⁸⁰³

Some tentative conclusions can be drawn from these case files. Of the twenty-one female patients treated for confirmed gonorrhoea between January and July 1817, almost all were treated with Copaiba and other natural remedies. Acidic astringents were applied to women's ulcers on a poultice containing lead, zinc, copper sulphate or iodine. Only one gonorrhoeal case was treated with mercury. Thus far, Chapman's proposals seem to have been put into effect. The sources are simply too ambiguous for any meaningful statistical observation regarding syphilitic women. Cases were sometimes referred to as 'chancre' or 'lues venerea' yet in general the blanket term 'syphilis' was recorded, making it difficult to positively identify distinct stages. That said, a close reading of the casebooks confirms that when mercury was used it was

⁸⁰² Mary Maybird, 12 Jan. 1817; Martha Miller 23 May 1816; Rachel Wilkins 23 April 1816, Case Notes.

⁸⁰³ Maria Coffee, Jan. 12, 1817 Surgical Case Notes; Carmichael, *Essay*, 211-213.

dispensed in limited doses. Moreover, it was often done so during a later stage of the treatment plan, normally preceded by botanic ingredients. For stubborn cases a small dose of the blue pill was given, and occasionally ‘hydr:fort’ (strong mercury) ointment was rubbed locally. Further, physicians exploited home-grown botanical compounds in the form of various barks and roots for patients with syphilis. In the first instance if the sore was considered syphilitic the surface would be dissolved by a local application of caustic astringents. Minerals and acids such as potassium iodide, lead, zinc or arsenical compounds were normally applied in mild solutions to the site of the disease. Calomel was certainly used by the medical team, although hardly in the heroic doses reminiscent of Benjamin Rush and therapy at the Pennsylvania Hospital. There also seems to have been a changing pattern of frequency between the 1804 Ledger and the 1816 to 1817 case notes, during which time the use of calomel was suspended.⁸⁰⁴ Purges throughout the period tended to be made from antimonies such as tartar emetic rather than the mercurial calomel. Even in the earlier period however, mercury seemed to be used as a last resort.

By the 1820s the pattern remained relatively unchanged and botanical remedies were still favoured by almshouse physicians. Moreover, it would appear that when mercurial preparations were resorted to they were still minimal. When twenty-six year old blacksmith James Dary was admitted in 1824, ‘the patient admits...in August last he took mercury to a considerable amount’, which he purchased himself ‘to avert the syphilitic disease’. Dary explained to the doctor that while ‘under the mercurial influence he took cold...and rhumatik pains’.⁸⁰⁵ The patient was clearly suffering from secondary syphilis and ‘today Dr. Chapman ordered the patient Syrup de Cinchona & a decoction of Sarsaparilla’. Subsequently, ‘this medicine was continued and the patient is nearly well’. He was discharged the next week ‘cured’. In a similar vein, another patient was admitted the same week and explained to the doctor in charge that ‘2 years ago he had syphilis in its primary stage’. The patient ‘applied to Mr. Swaim to cure his disease’. The notorious Swaim gave him ‘pills that made his

⁸⁰⁴ See Warner’s discussion on a comparison on the use of calomel by doctors from the 1820s to the 1880s at the Massachusetts General Hospital and Commercial Hospital of Cincinnati. Warner, *Therapeutic Perspective*, 122-3.

⁸⁰⁵ Dary’s case is also indicative that patient’s voices still remained an important aspect of diagnosis in the almshouse.

mouth sore'.⁸⁰⁶ Despite this alleviating his symptoms, the disease had returned with further complications. According to the physician in charge, 'last Saturday he entered the House and was put on the use of the Syrup de Conchina and ordered to drink largely of the decoction of Sarsaparilla'. Like James Dary, the patient was 'discharged well'.⁸⁰⁷ In a similar vein to the abovementioned women's treatments, the 1820s casebook is characterised throughout by the frequent use substances that were peculiar to the American native materia medica.

Furthermore, the traces of information scattered by various Philadelphian doctors and apothecaries lead us on a path to the almshouse ward which appears to differ from that followed by British doctors. The Dubliner Richard Carmichael's views were not representative of British doctors who tended to follow the orthodox standard, which sanctioned traditional mercury treatment. Siena suggests that even though guaiacum was sometimes used in London hospitals during the late eighteenth century, mercury was the dominating therapy. Moreover, it was used liberally and normally carried to salivation.⁸⁰⁸ Therapeutic practices varied widely within Europe. According to Wyke, despite the warnings by the mid-nineteenth century 'mercury was not as widely rejected in England as on the continent'. This is substantiated by F.B. Smith, who claims of British medicine for venereal disease that 'mercuric bichloride [calomel] or arsenate comprised the main treatments until the 1860s and 70s when they went out of fashion and were replaced by potassium iodide, sarsaparilla, rhubarb, tamarind, purges, rest and general cleanliness'. This was because these compounds were better-known for their 'milder side-effects' than mercury regimes.⁸⁰⁹ In the almshouse however, they had been in vogue for a considerable length of time.

We can compare a Philadelphia Almshouse physician's venereal treatment with a British doctor's. John Redman Coxe who practiced in the almshouse in the 1790s explained,

⁸⁰⁶ Recall this patent remedy was found to contain corrosive sublimate.

⁸⁰⁷ *Guardians of the Poor*, Philadelphia Almshouse Hospital, Medical Record of Cases in the Clinical Wards, 1824, PCA.

⁸⁰⁸ Siena, *Venereal Disease*, 81-3, 151-52.

⁸⁰⁹ Wyke, 'Hospital Facilities', 81; Smith, 'The Contagious Diseases Acts', 214. Walkowitz likewise claims 'mercury continued to be the primary although not exclusive treatment for syphilis...until World War 1'. Walkowitz, *Prostitution*, 52.

As to the case in question I suspected its venereal origin; but to adopt a successful mode of treatment was a more embarrassing task...it seemed like attacking the enemy in an ambush who assailed you from all quarters. Suffice to say, that the symptoms abated much within three weeks, under the copious use of decoctions of sarsaparilla, emulsions of pearl barley...a light soup diet, a daily moderate use of tincture guaiac...[and] warm injections of milk and almond oil with a few drops tincture of opium added to each injection. From the end of the third week, sarsaparilla and barley emulsions only were used. At the end of the fifth week, every vestige of disease had vanished, and an invigorating diet was recommended which soon recovered the patient.⁸¹⁰

British doctors tended to employ the reverse order; if syphilitic ulcers did not yield to mercury, the patient would then be treated with a decoction of sarsaparilla or guaiacum. An example from St. George's hospital in London is revealing. Apparently the patient was at death's door after being subjected to excessive salivation, and according to the doctor,

The Nightshade (corrosive sublimate) was discontinued and the remarkable success we had in a similar case not long before with the decoction of Sarsaparilla root, made us recommend it for this poor creature but with very little hopes of success or her life...She took it with milk...and in a months time her sore healed...and she recovered her health and strength.⁸¹¹

All told, the case records are full of examples which point towards a considerable and sometimes singular use of natural ingredients employed as cures in secondary syphilis. However, we should return to the suggestion that when mercury was resorted to, it was done so in small doses. Mary Montgomery's case is typical, and on 20 April 1816 she was admitted with syphilitic sores and eruptions. On her first day she was prescribed with a teaspoonful of mercury ointment to be 'used daily to rub' along with a daily gill of whisky. On the 26 April the doctor 'omit[ted] the mercury' and she was discharged cured. From the day mercury was prescribed to Mary until the day she left the venereal ward, there was simply not enough time for the drug to encourage salivation let alone sustain the procedure. Nor was the dose high enough. More forcefully put, when mercury was dispensed it was not carried to the extent of salivation. Writing in the 1830s Irish physician Abraham Colles explained that if the mercury pill was faithfully administered every day, and probably more than once a

⁸¹⁰ John Redman Coxe, *Philadelphia Medical Museum*, Vol. 6 (1809), 143.

⁸¹¹ William Broomfield, *An Account of the English Nightshades and their Effects* (London: R. Baldwin, 1757), 28.

day, there would be no effects normally until the seventh day, when ‘ptyalism is fairly established, the gums are swollen and appear as if inclined to separate from the teeth’. The evidence implies that the use of mercury in the almshouse was used to an even lesser degree than the actual recommended ‘safe’ dose by the medical profession, and the standard dose of blue pill on the market was made up from around five grains of mercury. The Philadelphia editor of Carmichael’s *Essay* is informative:

The hydrargyri oxymurias in such minute doses as hardly will be sensibly felt by the patient- namely one-eighth or one-tenth of a grain in pills or solution twice a day, frequently acts a charm in healing ulcers of a very indolent character.⁸¹²

When one almshouse woman suffering from syphilis was admitted, she was prescribed a decoction of sarsaparilla with 2 grains cicuta and a quarter grain of ‘pil: hydrarg’. This was therefore a very small dose of mercury.⁸¹³ When the blue pill was dispensed in the almshouse therefore it was done so in highly controlled dosages. George Smith, a physician giving a clinical lecture on syphilis in the 1860s contended that ‘in the early stages of disease, depletion in any form is unwarrantable’. However, for secondary symptoms, ‘mercury, judiciously given, that is, *short of the point of salivation*, is [a] trustworthy remedy in these cases’.⁸¹⁴ Whether through financial expediency or individual medical opinion regarding venereal treatment, this appears to have been a common therapeutic course followed by almshouse doctors treating syphilis.

Yet we still have to account for the fact that a number of venereal patients remained in the almshouse for lengthy periods.⁸¹⁵ Interestingly the average number of weeks a syphilitic woman spent in the almshouse was longer than Siena’s London patients

⁸¹² Dymond, *Srutter’s Casebook*, 1. The editor also proposed the use of ‘zinc ointment...either alone or with a third or fourth’ of the mercurial pill. This was regularly adhered to in the almshouse infirmary. Carmichael, *Essay*, 94.

⁸¹³ Colles recommended the safest dose of five grains mercury in the ‘pil:hdyr’. Abraham Colles. *Practical Observations on the Venereal Disease and on the Use of Mercury* (Philadelphia: A. Waldie, 1837), 26.

⁸¹⁴ George Smith, M.D., ‘Clinical Lecture on Syphilitic Retinitis’, in *Madras Quarterly Journal of Medical Science*, Nos. xxiii and xxiv.

⁸¹⁵ A database compiled from a sample year in 1807 points towards women who used the most expensive medicines as being those who were suffering early symptoms of secondary syphilis. This is clearly the case because those with the highest bills were still physically able to elope. In addition, they were more likely to be long-stay patients, which would be expected given the cost racked up in medicine bills. Often the bills were doubt carried over from a previous admission where the cost was not met by the patient.

who were treated with mercury. Carmichael's response to the death of a patient from mercury poisoning is revealing: 'if antimony and sarsaparilla are persevered with in steadiness, under confinement the patient would probably have recovered in the course of eight to ten weeks, and with but little suffering'.⁸¹⁶ Mary Hayhart is a typical example of women who displayed signs of constitutional syphilis and remained for a considerable spell in the ward. In January 1817 she was admitted into the ward and ordered to take a decoction of sarsaparilla, and 'simple ointment' containing ipecac. This was accompanied by 'tonic treatment [of] porter [ale] ... [and] a generous diet'. She remained in the ward on this plan until April, when 'Brandy ½ pint' was added with a continuum of her daily decoctions of sarsaparilla. In early June her sores had not disappeared and she was prescribed sulphate of zinc. Still displaying inflamed ulcers she was then ordered to take a small dose of calomel & jalap. She left 'cured' a few days later.⁸¹⁷ Mary's treatment is informative. She was not prescribed mercury until five months into her treatment, which until now was based on herbal medicines. She was discharged officially before salivation could occur, which was unlikely from the small and singular dose. Moreover, she did not return to the ward. As noted, some patients actually contested an official discharge. If a longer stay meant free food, alcohol and opium for diseased women, then the chances are that for those particularly impoverished, they would have welcomed the longer stay.

On the one hand, we cannot merely presume that the most common medicines from the polishing room medicine cabinet were totally effectual. Yet natural ingredients such as ipecac, sassafras, guaiacum and sarsaparilla were used in considerably larger doses than mercury, or other metals and minerals, and it has been suggested that most of them were nevertheless harmless. In fact, according to Duffy, 'many of the drugs administered by physicians such as cinchona bark...ipecac...opium, and a host of emetics and cathartics, were effective'.⁸¹⁸ Although guaiacum was as bad as mercury for inducing sweating and not actually effective in treating syphilis, it was nonetheless innocuous. It has also been suggested that copaiba and sassafras are especially effective in treating some symptoms of venereal diseases if used in controlled

⁸¹⁶ Carmichael, *Essay*, 247.

⁸¹⁷ Mary Hayhart, 12 Jan to 7 June, 1817, Case Notes. Physician-historian Parascandola suggests that mercury was effective in temporarily suppressing symptoms. See Parascandola, *Sex, Sin, Science*, 28. Thus, in Mary Hayhart's case, her cure was more gradually brought about by botanical compounds, with the mercury displaying a pseudo cure.

⁸¹⁸ Duffy, *Humors*, 45; Allen, *Wages of Sin*, 52-56; Quetel, *History of Syphilis*, 32.

dosages.⁸¹⁹ Although the frequency and quantities of natural ingredients used in the infirmary exceeded that of mercury, financial constraints dictated that dosage was tightly controlled, with opium and alcohol perhaps the exception.

In any case, doctors were increasingly moving away from the theory based directive most commonly associated with Rush, which dictated that the whole body should be saturated with mercury. When mercury was used, it was often externally applied to localised sores with the use of a cold poultice. For those who were prescribed mercury orally, the dosage and duration of hospitalisation would not have exposed the patient to the poison long enough to absorb the metal throughout the body. As outlined in chapter four, the blue pill was easy to come by, yet when it was used in the almshouse it appears to have been restricted to cases of full-blown syphilis. This may have saved the lives of numerous women with minor symptoms who turned to the almshouse first, and in fact only used the infirmary facilities on one occasion. It also helps to account for the severely diseased state of other women who turned up on their first visit.

The above evidence may also explain a relatively low mortality rate of diseased almshouse women, including those who were re-admitted. As shown, gonorrhoeal ulcers were a common almshouse diagnosis, and as is known, they may be resolved without treatment.⁸²⁰ Furthermore, it has been claimed that in primary syphilis, the sore could remain outside the body and heal spontaneously after a few weeks, even in the absence of treatment. Thus syphilis could eventually run its course.⁸²¹ If patients underwent a course of therapy devoid of mercurial preparations, this would explain why so many women were not readmitted, and presumably returned to their lives apparently restored to health. It might also help explain why so many prostitutes appear to have sought out medical treatment in the almshouse infirmary. Quite simply put, it may have been the least invasive, safest and apparently most effective treatment available. And it could be received very much on diseased women's own terms.

⁸¹⁹ Steven Foster and Varro E. Tyler, *Tyler's Honest Herbal: a sensible guide to the use of herbs and related remedies* (New York: Haworth Herbal Press, 1999), 337.

⁸²⁰ Lowry, *Venereal Disease*, 79; Quetel, *History of Syphilis*.

⁸²¹ Ibid.

Moreover, and especially for patients suffering from minor symptoms, recourse to herbal or vegetable medicines certainly withheld doctors from resorting to mercury long enough for the body to work with natural ingredients or indeed with nature itself. By refraining from invasive therapy, diseased women's bodies could work in tandem with nature to expel its poisons and thereby aid its own healing process. As indicated, the idea of letting nature dominate over the physician was becoming more popular. This was part of a general shift in attitudes supported by Philadelphia's medical community who were in favour of milder therapeutic plans characteristic of the Montpellier Method. For some doctors, the idea was a foreign -and quite loathsome- concept, particularly those like Rush who believed in the one-disease theory and ultimately sought to heal the body as a whole. And for the many apothecaries, irregulars and charlatans who flooded Philadelphia's open medical market, Mother Nature was simply the devil in disguise. Returning to the yellow fever epidemic, we saw that Philadelphia's doctors were not a homogenous camp of Rush enthusiasts. Many almshouse residents deplored depletive therapy in general, with Kuhn and his followers proposing the healing power of nature itself as the best remedy.⁸²² According to an estimate by Estes, a sizeable proportion of Philadelphia citizens, anywhere 'from 50 to 90 percent' were infected yet survived as a result of the body's 'remarkable ability to heal itself'.⁸²³ If we apply this theory to almshouse venereal therapeutics, the evidence suggests that those who recovered did so not only from natural remedies or limited amounts of mercury, but also the body's natural response. A combination of almshouse economy and personal preference "from above" to treat venereal disease with mild treatment plans prevailed in the infirmary.

6.6 A Class Experience

It is virtually impossible to fully appreciate how a woman perceived her stay in the Philadelphia Almshouse. It is a reasonable presumption that for many women a trip to the polishing room meant access to respite, opium, alcohol and sometimes, a generous diet. Recourse to alcohol and opium cannot be overlooked. We already know the managers continually reprimanded the physicians for their heavy reliance on alcohol

⁸²² The intention is not to overstate a definite divide for and against Rush, however, as Rush himself proclaimed, his supporters were indeed mercurial men. Powell, *Bring out your Dead*, 122.

⁸²³ Estes, 'Yellow Fever Syndrome', 7.

as a medicinal ingredient. The doctors always stood firm and on one occasion claimed, 'Wine is a necessary prescription & Brandy is wanted to make Tinctures'.⁸²⁴ Women who had experienced years of venereal pains were no doubt more concerned about getting their hands on alcohol and opiates to ameliorate the mental and physical effects of disease. This may even have motivated a decision to go to the almshouse, and treatment for disease may not have entered a woman's mind. This is supported by examples in the casebooks where women in late stages of disease were treated only with narcotics such as laudanum and opium. Diseased women who were familiar with the layout of the infirmary were no doubt aware that medicines and alcohol were often carelessly left lying around in unlocked cabinets, thus they could often quite easily access their drink or drug of choice.⁸²⁵

We also cannot be sure how women felt about the medicines that arrived at their bedside. To be sure, many no doubt eagerly consumed them because they kept coming back for more and no doubt simply out of the sheer desperation to feel better. Historians have suggested other factors were at play by highlighting a ritualised aspect of healing. In this interpretation, patients needed to see proof that their medicine was working, or what the medical profession commonly preferred to term as 'exhibition' of drugs. This is clearly illustrated during a ward-round in the Pennsylvania Hospital. When the physicians reached the bed of a patient being treated with mercury, the attending doctor recorded in the patient's file: 'Dr. Rush...ordered the mercurial ointment to be rubbed into his sides in order to excite a salivation'. In fact, so delighted was Rush with the result of this abrasive treatment, he was 'highly gratified to hear him [the patient] complain of swelled gums and great pains in his teeth'.⁸²⁶ From the patient's perspective of this interpretation, he or she had to see and feel the drug actually working, thus the more drastic the treatment, the more content a patient was with their therapy. Thus, salivation symbolised the culmination of therapy as the body was perceived as being en-route to a healthy state. Yet this was also dependent on the fact that both physician and layman held the same views on the manner in which the body functioned. Therapeutics from this perspective significantly cemented the relationship between doctor and patient, and was an important ritual in

⁸²⁴ 9 Mar. 1789, M.M.

⁸²⁵ For instance, see 21 Nov. M.M. Chapman advocated the 'free use of Porter in the venereal disease', 'Chapman's Notes, Vol. 2', 274.

⁸²⁶ Hospital Cases, Vol. 1, 1803.

the sickroom.⁸²⁷ One of the reasons gentler remedies gave way to harsher treatments in early modern Europe, was because patients believed if they could feel the therapeutic action, it was taken as a cure.⁸²⁸

Yet, this approach did not suit every sick person. Moreover, patients who relied heavily on a ritualised ‘exhibition’ of drugs tended to be drawn from the wealthier classes, perhaps simply wanting proof of purchase. This is most clearly illustrated in almshouse doctor James Anderson’s journal taken during his private rounds.⁸²⁹ Anderson seems to have been particularly fond of using botanical remedies and opiates, something he had perhaps picked up during his Philadelphia Almshouse training prior to setting up a private practice in Chester County. Anderson visited a patient suffering from a case of fever and attempted to dose the patient with laudanum. The doctor exclaimed ‘I was determined to quit the arsenic but this was first objected to by the parents’.⁸³⁰ This suggests that the patient who could afford bedside medicine demanded the cure to be as visible as possible. One eighteenth century doctor lamented ‘what is annoying about the upper classes is that when they come to be sick, they absolutely want their doctors to cure them’.⁸³¹ The placebo effect looms largely in this interpretation. Thomas Jefferson was aware of those patients who counted upon their physicians to be more than a ‘watchful, but quiet spectator of the operations of nature’. Jefferson was especially wise to the tendency of doctors to manipulate this aspect of healing when dispensing medicines to patients who filled their coffers. He passed remark on,

...one of the most successful physicians I have ever known has assured me that he used more bread pills, drops of coloured water, & powders of hickory ashes, than all the other medicines put together. It was certainly a pious fraud.⁸³²

⁸²⁷ For a fuller discussion on the idea of ‘exhibition’ as an important cultural ritual in therapeutic practice, see Rosenberg, ‘Therapeutic Revolution’, 16-22, especially 17. Rosenberg suggests laymen often demanded severity from their doctor, to the extent that ‘laymen frequently bled themselves and friends, sometimes with such enthusiasm they found themselves in a hospital bed’. Rosenberg, *Care of Strangers*, 77.

⁸²⁸ Allen, *Wages of Sin*, 52.

⁸²⁹ For a detailed discussion of this casebook see appendix four.

⁸³⁰ James Anderson, ‘A History of Certain Cases taken by the Author during his Residence in the Philadelphia Almshouse, October 1804 to May, 1806’, HSP.

⁸³¹ Allen, *Wages of Sin*, 59.

⁸³² Thomas Jefferson quote taken from, Rothstein, *American Physicians*, 44.

It could be argued that the poor did not share this luxury of dictating their treatment of choice. Perhaps they simply did not want to. If patients wanted to see and feel the exhibition of mercury they could do so quite easily and relatively cheaply without a trip to the almshouse. It was commonly assumed -by doctor and lay person alike- that mercury was not without its dangers, thus we can suggest that diseased women were aware that the cure was worse than (or at least as bad as) the disease itself..⁸³³

Unlike yellow fever or later cholera, which have been termed by historians as class specific diseases, the pox did not select its victims depending on a person's standing in the social strata. However, the experience of the rich differed markedly from the pauper experience and a person's social position did undoubtedly shape the victim's experience of venereal disease. Thus, like all sickness a person's experience of venereal treatment took place in either the private or public sphere. William Chew's friend could indulge in the option of having a physician make a personal house call. A few prostitutes lived in a brothel where physicians routinely visited. Yet, by and large the luxury of privacy and secrecy was something most almshouse women did not have. The further the disease progressed, so too did the likelihood that she would be turned out of the brothel because of her liability to deter clientele. Ironically, it seems the richer the patient, the more likely that treatment would be deadlier than the disease. To this end, those who could afford it paid as highly for their infection as they did for their cure: diseased almshouse women were therefore at an advantage.

Furthermore, while Rosenberg notes that a permanent underclass defined European cities, Americans in the late eighteenth and early nineteenth centuries did not believe they shared the same disparities of wealth. This influenced the way epidemic diseases were perceived.⁸³⁴ From the 1830s however, attitudes about the poor changed as wealthier citizens increasingly accused them as being morally responsible for their lot. Thus when cholera hit hard in 1832 its victims became more associated with poverty, squalor and vice. In the earlier period victims suffering from venereal infection were not marginalized by class distinctions. In fact, the pox was often associated with the

⁸³³ For a rather different interpretation see Temkin, 'Therapeutic Trends', 316. According to Temkin, 'common people accepted the terror of the mercurial cure as a punishment for their sins', while wealthier sections of society 'were less inclined to seek moral improvement from their physicians and preferred a treatment less severe'.

⁸³⁴ Charles Rosenberg, *The Cholera Years: The United States in the years 1832, 1849 and 1866* (Chicago: Chicago University Press, 1987), 20-39.

lavish lifestyles and excesses of the upper classes.⁸³⁵ The period from the early republic through the early ante-bellum years represents a moment in time when venereal disease was not associated with the lower sort, and indeed, Philadelphia's residents seemed more forgiving of diseased women than they would a generation or later.⁸³⁶ The records left by doctors do not suggest that they held the poor or prostitutes to be culpable for the spread of disease.

Moreover, venereal disease, although still constituting a significant problem amongst specific groups, is not now an endemic disease to the extent it was in the past.⁸³⁷ In eighteenth and early nineteenth century Philadelphia, prostitution was simply part of the social landscape and venereal diseases in its various forms was often on public view. Siena makes this point most succinctly in reference to London's foul wards,

Attempts at moral reformation were not the primary impetus behind early hospital provision for the Pox...those directing charitable resources towards treating venereal disease were waging a different battle. Hospitals were not fighting widespread moral turpitude...but venereal infection. Were our hospitals today so dominated by a single disease-if a single diagnosis accounted for one fifth to one quarter of all hospital patients- the headlines would read daily of one of the worst public health crisis in recent memory.⁸³⁸

Similar to London of a slightly earlier period, venereal disease was omnipresent in Philadelphia and the proportion of beds occupied by venereal patients in the almshouse infirmary and the hospital for the sick poor hovered around 20 percent of the total patient population. In any case, in an age when people did not benefit from penicillin venereal disease appeared to be rampant in this large port city. Philadelphia's citizens would have almost certainly been witness to the visible scars

⁸³⁵ Interestingly, the almshouse also treated those who were once wealthy but also citizens who held a connection with almshouse physicians. There are several instances of inmates having personal connections with almshouse doctors. A well-connected Philadelphian apothecary, descended from a wealthy French family died in the institution after being treated for delirium tremens. Moreover, two of his brothers were distinguished Philadelphia physicians. See, Osborne, 'Detestable Shrine', 128.

⁸³⁶ Although yellow fever was a class-specific disease, Mathew Carey was exceptional for a contemporary in associating the disease with poverty and publicly announcing how the epidemic hit the pauper class most severely.

⁸³⁷ STD's have been on the rise again in the West in the early years of the twenty-first century, most notably amongst younger age groups. Syphilis has re-appeared, especially in America, while rates of chlamydia are increasing on both sides of the Atlantic. In 2008, public health experts claimed rates of chlamydia in the south of Scotland had risen by 60 percent.

http://news.bbc.co.uk/1/hi/scotland/south_of_scotland/7553764.stm, Last accessed, 1 December 2009.

⁸³⁸ Siena, *Venereal Disease*, 10.

of infection and mercury poisoning inscribed on the bodies of many of the city's residents, rich and poor.⁸³⁹ Despite its Quaker influence, the sexual atmosphere of Philadelphia was lax, promiscuous and brothel directories were the "norm". Men indeed bragged about having the clap.⁸⁴⁰ As John Hunter remarked, 'most men have had venereal complaints at some time or other'.⁸⁴¹ Bynum makes this point about Britain during a period prior to the Victorian era, when liberal sexual values were comparable to those of Philadelphia's early national period.

The sexual openness of Enlightenment values in those days of directories of prostitutes and public mistresses...where sexual intercourse could be depicted as a relatively uncomplicated physical act, without the psychological overtones it would later to acquire, and where young men were expected to sow a few oats.⁸⁴²

We have seen several instances of almshouse physicians displaying compassion towards their venereal charges. Indeed, doctors saw first-hand how severely the condition could affect their patients, especially those in its later stages of infection. Unlike John Cummings the steward, physicians did not show signs of singling out prostitutes as being responsible for their condition, and the Dockets themselves seem less disparaging against diseased women after the arrival of a new steward in 1803. Thus, women were now noted as 'cruelly distempered' and 'brought in a distressing condition'. Moreover, anecdote also gave way to fact and diseased women were now

⁸³⁹ In areas such as port cities where venereal disease runs widespread and unchecked, society takes a more lenient stance, more so than we would now be accustomed to in the case of sexual disease. During the AIDS panic in the 1980s specific groups perceived as an underclass were targeted, and gay men were singled out and blamed as agents of transmission. Jan Mackell points out to the Western towns during the gold rush (where the incidence of venereal disease can be compared to Philadelphia in the late eighteenth century): 'in those days venereal disease was taken fairly lightly by the general public, probably because it was so rampant'. She also finds that some men even bragged about being infected, a point that has also been noted by Lyons of early national Philadelphia. Jan Mackell, *Brothels, Bordellos and Bad Girls: Prostitution in Colorado, 1860-1930* (Albuquerque: University of New Mexico Press, 2007), Lyons, *Sex among the Rabble*, 247-253.

⁸⁴⁰ William Chew's letters of correspondence are striking for the seeming flippancy held his friend William Shepherd, who came down with 'the most violent clap'. Yet, a flippant attitude by Shepherd is twinned with the sense that the young man was gloating about being infected, as if proving his manhood. 'Letter to William Chew', 2 Oct, 1820.

⁸⁴¹ John Hunter, *A Treatise on the Venereal Disease* (Philadelphia: 1786), 169.

⁸⁴² Bynum, 'Wages of Sin', 6. Leon Guilhamet makes an interesting observation connected to satirical representations of the pox in the eighteenth century. He suggests references to venereal disease began to disappear from English satire when the incidence of the pox rose, and became more noticeable for its presence on every rung of the social ladder. Previously it was used by Whig satirists as a political tool to attack Tory monarchists and the aristocracy, a group who were 'most ostentatious' in their display of mistresses. However, this waned and the disease 'became so accepted at every level of society that few could muster the boldness to single it out as the stuff as satire'. See Leon Guilhamet, 'Pox and Malice' in, Merians, *Secret Malady*, 209-10.

‘unwell’ or ‘very much injured with the venereal’. And there was little in the way of the blame reminiscent of Cumming’s notations, thus women were now ‘afflicted’.⁸⁴³

Historians have a natural tendency to view the nature of medical treatment dispensed by doctors to prostitutes as veiled with a darker purpose. It seems almshouse physicians were opposed to prescribing doses of rough justice towards those groups who some wealthier citizens did hold accountable for infecting the city. In 1825, the managers received a complaint from the physicians about ‘the propriety of employing patients on the Tread Wheel who are discharged from the syphilitic wards’. The doctors had been ‘directed’ by the Managers to put diseased patients through this ordeal, and the medical team simply could not see the reason for putting convalescent diseased patients through such an ordeal’.⁸⁴⁴ Siena also disagrees with historians who, like Temkin suggest ‘harsh mercury treatment served as rough justice’.⁸⁴⁵ If more research is carried out to ascertain the nature of therapeutics actually employed in workhouses or almshouses, we may be able to paint a more detailed picture of pauper medicines. In any case, aside from John Cummings (who would have been allowed little say on the matter anyway) almshouse officials had more of an eye on their budget than they did on the morals of their patients, and physicians were more concerned for those victims ‘eaten up with disorder’ above all.⁸⁴⁶ Thus punitive medicine simply did not loom large.

6.6 Discharged from the Almshouse Cured

When a women left the almshouse she would be recorded in the registers as discharged cured, relieved, eloped or died. Historians agree with Wyke that ‘the disease was generally pronounced cured with the disappearance of the external

⁸⁴³ See for example, Mary Drake 28 Oct. 1804; Sophia Curry, July 1807; Sophia Smith, Feb. 1809, Dockets.

⁸⁴⁴ 2 Jan. 1826. M.M. The tread wheel was a mill powered by humans or animals, which drove the machinery in the almshouse factory. According to Clement, the managers ‘expected the factory’s tread wheel to continue to promote economy by discouraging applications for institutional relief’. They dispensed with it when the almshouse relocated to Blockley. *Welfare and the Poor*, 101-109.

⁸⁴⁵ Siena, *Venereal Disease*, 85. Siena remarks, ‘the hospital records do not indicate that this was an openly acknowledged motive’. See Temkin, ‘Therapeutic Trends’, 316; Walkowitz, *Prostitution*, 55.

⁸⁴⁶ Elizabeth Thornton, Dec. 1804, Dockets.

symptoms'.⁸⁴⁷ Most contemporary doctors were unaware that between the second and third stages of syphilis the infection had the potential to lie latent. Thus, after the second stage it was thought that the disease had been eradicated, and re-admissions were often mistakenly interpreted as re-infection. As outlined in chapter three, 57 percent of diseased women made multiple visits to the infirmary between 1812 and 1818, and the period prior to 1800 shows a similar pattern. When Elizabeth Moffat was re-admitted it was documented that 'she wasn't cured last time'. Thus when a woman was deemed to be cured, physicians believed she was literally free of disease. When Susannah Morgan was re-admitted nearly a year following a previous admission, she was 'cured from the venereal before', and Margaret Hess was 'diseased again' although she had been 'only cured ten days ago'. Mary McCulloch's diagnoses are particularly revealing. Her constant re-admissions were regarded as new infections each time rather than relapses of the original infection. During one admission it was observed that she 'gets venereal disease eight to ten times a year'. There is plainly no space in these diagnostic transcripts for a latent period of infection. John Cummings does seem to have been dubious of some diagnoses. When Priscilla Wilson was officially discharged from the infirmary, the steward pointed her out as 'cured (or mended)'.⁸⁴⁸ In short, the visibility of a woman's disease would dictate if she would be discharged cured.

The evidence often reveals that patients attempted to thwart an official discharge by alleging themselves still unwell. The physicians bought into this ploy (if it was indeed a false strategy). Doctors were often wrapped on the knuckles by the managers who would inspect the wards and point towards diseased patients who 'appear in good health'. On one occasion the managers castigated the physicians and demanded that they 'select from the venereal wards all such cases that may be deemed convalescent'.⁸⁴⁹ Despite the large numbers of elopers, venereal patients in particular

⁸⁴⁷ Wyke, 'Hospital facilities', 83. According to Risse, the label 'cured' was used liberally to denote partial cures, or indeed a full cure even when discharge was speedily followed by re-admission. Gunter. B. Risse, *Hospital Life in Enlightenment Scotland* (Cambridge: Cambridge University Press, 1986), 230-1.

⁸⁴⁸ Priscilla Wilson, Oct. 1794; Elizabeth Moffat, June and August 1801; Margaret Hess, May 1794; Mary McCulloch, April, 1791, Dockets. That so many patients were readmitted also lays substance to the curative role of the almshouse infirmary.

⁸⁴⁹ 31 May, 1802, 17 Jan. 1803, M.M. The physicians retaliated to this interference by announcing during their own board meeting that the 'junior doctor shall frequently visit the wards for the able-

seem to have entertained the idea of a lengthy stay. Tomkins has suggested that English workhouse infirmary patients had a lesser tendency to elope and ‘the acquiescence of their treatment can be inferred from their propensity to remain on the hospital books’.⁸⁵⁰ This seems to be the case for many almshouse women who did linger around the polishing ward for a considerable time. Others eloped very quickly, yet this does not necessarily infer they were so traumatised by their medical treatment that they took to their heels prematurely, as Siena has suggested of London patients. Simply put, they obtained the course of treatment they deemed necessary, and then returned to their families and jobs.

Despite the crippling nature of advanced stages of venereal diseases, surprisingly the majority of sick almshouse women left the infirmary alive. A database spanning nearly forty years (therefore accounting for women who may have returned some years later) sheds valuable light on mortality rates of diseased almshouse women. Out of 959 female confirmed venereal admissions between 1786 and 1811 for instance, only 7 percent were recorded as dying in the institution.⁸⁵¹ In the 1802 annual Statement published by the almshouse medical department, only 2 out of 124 ‘syphilitic’ were recorded as ‘died’.⁸⁵² As Jutte suggests, we need to be sceptical of placing too much confidence in mortality rates as an ‘accurate barometer of therapeutic effects’. Yet he points out in his study of German venereal disease patients ‘we do not know if patients were really suffering from venereal disease or from some other ailment displaying similar outward signs and symptom’.⁸⁵³ Jutte’s subjects were only referred to as ‘syphilitic’ and fortunately the almshouse records are not as restricting. Of the 62 patients admitted during the same year in 1801 with ‘ulcers’ (some noted as ‘acute and chronic’) only 2 died.

bodied in the House of Employment’, and ‘if he finds any sick person there, remove them immediately for medical care’.

⁸⁵⁰ Tomkins, *Experience of Urban Poverty*, 140.

⁸⁵¹ The database is compiled by computing patients who were recorded in the Dockets, with cross-referencing with related registers. Re-admissions were omitted unless the patient died. The problems arising from this have been attended to already with respect to patients with ulcers or venereal disease. Only those deemed venereal by the steward were included. The incidence of mercury poisoning also makes it difficult to ascertain diagnosis, which is further compounded by the use of multiple names by some women.

⁸⁵² 102 patients were noted ‘cured’, 17 patients ‘relieved’ with the rest remaining in the house. ‘Statement of the Sick and Surgical Cases under the Care of the Medical Department in the Almshouse and House of Employment’, March 1801-March 1802.

⁸⁵³ Jutte, ‘Hospitals in Early Modern Germany’, 111-12.

Given that many women were admitted suffering from minor complaints, and if they underwent a relatively gentle course of therapy, they may indeed have been cleared of their infections. This would also corroborate with Nathaniel Chapman's contention that many complaints were not actually venereal. This has implications for historians, because as much as we contend that venereal disease was rampant the straight answer is we simply cannot quantify this definitively. An official discharge labelling a sick pauper as cured was no doubt important to diseased almshouse women, suggesting they used this resource for a certification of health by a qualified practitioner.

There are three overall points to be drawn from the above evidence. First, Americans were passionate about home-grown remedies, and while almshouse doctors were certainly not completely averse to mercury or acidic and mineral compounds, the use of natural ingredients remedies was standard procedure. Pharmacopeia native to the Americas were prominent in the medical lists sent to the almshouse managers and a notable feature of actual therapeutic practice. This supports Norman Gevitz's claim that 'Americans -both lay and professional medical practitioners- tended to be more receptive to herbal remedies than their British counterparts'.⁸⁵⁴ Philadelphia Almshouse doctors were especially inclined towards botanical medicines. Second, financial expediency prompted minimal drug use and also cheaper preparations. While drugs such as sarsaparilla and guaiacum were luxurious imports to the British they were less expensive in the land they were grown. Plant-based drugs such as guaiacum, ipecac, sarsaparilla and sassafras were often referred to as New World remedies. This is an important aspect when drawing distinctions between American therapeutics and those carried out in Britain. Overseas such drugs were commodities that commanded a high price. Third, diseased women's experience in the late eighteenth and early nineteenth centuries was happening during a time of changing opinions on the efficacy of mercury and also a broader transition in diagnosis and pathology. Although the next generation of doctors would be more notable for being the Paris School, the French presence in Philadelphia was profound during the late colonial and early republic years and French ideas disseminated through the Philadelphian medical community.⁸⁵⁵ Even if this important aspect was removed

⁸⁵⁴ Norman Gevitz, 'But All those Authors are Foreigners', 244-5.

⁸⁵⁵ John Harley Warner, *Against the Spirit of the System: the French Impulse in Nineteenth Century American Medicine* (Princeton: Princeton University Press, 1998).

from the equation, economic dictates would have rendered therapy in the almshouse unwittingly comparable to the Montpellier model of gentler methods of healing. American doctors took inspiration from their counterparts in France, where doctors were increasingly rejecting saturating their patients with mercury. Mercury was not prescribed in cases of common ulcers or gonorrhoea. Further, the evidence does not imply that women with confirmed syphilis were treated abrasively, and covered head to toe in mercury. Rather when mercury was applied it was dispensed directly in a small amount to the site of the sore. Moreover, alternative mineral acids seem to be preferred and used as astringents to destroy venereal sores.⁸⁵⁶ It is clear therefore, that almshouse doctors practiced what they preached.

At the end of chapter five a question was posed: did physicians' lectures to their students on the subject of venereal treatment translate into practice? The answer is quite simply that they did. To sum up polishing room practice we will turn again to Carmichael, partly because of his profound influence on Chapman. 'Be it remembered' he declared 'vegetables alone, when properly prepared will effect a cure although in others it must be acknowledged that minerals will likewise be required'. Philadelphia doctors who shared these views surely influenced women who were treated for venereal infection in the almshouse. Although Chapman was just one of many distinguished doctors who practised as resident physician he was highly influential. In 1830, Isaac Hays an 'eminent physician' and one-time student of Chapman wrote a preface to the American edition of the French text *Memoir of the Treatment of Venereal Diseases without Mercury*, by H. Desruelles, M.D. On behalf of those doctors attached to the infirmary dispensary he stated,

For ourselves, in ten years practice, we have never put a patient through a mercurial course for any form of venereal affection, and for the last six years we have not used a particle of mercury in the treatment of this disease, and have never had reason to believe that our patients were less speedily or less effectually cured than those treated with mercury Of those treated by use for primitive symptoms, in the Philadelphia and Southern Dispensaries, and in private practice we know of but two cases of secondary symptoms, and this was cured in four days.⁸⁵⁷

⁸⁵⁶ Quétel, *History of Syphilis*, 116.

⁸⁵⁷ H.M.J. Desruelles, *Memoir on the Treatment of Venereal Diseases*, ix-x. For reference to Hays as a student of Nathaniel Chapman see, Robert M. Veatch, *Disrupted Dialogue: Medical Ethics and the Collapse of the Physician Humanist, 1770-1980* (Oxford: Oxford University Press, 2005).

Conclusion

The early national period saw great confusion in the methods of social disciplining within the relatively new structures of confinement. This was particularly the case in the Philadelphia Almshouse, and the narratives left by various officials elucidate the various power struggles at play. With no real precedent for indoor relief, city and almshouse officials faced the problem of implementing new ideas of and continuous bickering and uncertainty over the bona fide purpose of the almshouse left a vacuum of power. As a result, John Cummings -the almshouse steward and one of the most senior on-site administrators- ended up playing a vital role in the institution and in the lives of diseased almshouse women. The steward contributed significantly to the texture of almshouse life, and his story is crucial for providing a framework into understanding how diseased women experienced the almshouse. What can be made of the elaborated nuances of would-be residents embedded within John Cummings records? The face-to-face admission interviews with the steward provided women like Rachel Ward with a platform to negotiate medical care through the public poor relief system. When women applied for admission they encountered a steward who found some of them repugnant, yet he was also intimidated by this poised and sometimes brazen group. In the face of castigation by Cummings, diseased women developed a range of techniques to deal with such strong and doubtless visible resentment. While female venereal inmates recognized that they had to adhere to the rules of officials, they adopted various strategies to secure what they believed was rightfully theirs. While diseased women's behaviour could be construed as insubordinate, an unspoken contract existed, enabling women to express agency through a variety of tactics, both individually and collectively. Moreover, while they often appeared as aggressive, sly and underhand, this was in part the steward's interpretation of their actions and motives. Negotiation often materialised as a theatrical display of sorts, in which the actors knew their place and firmly guarded their entitlements and traditions.

One could argue that whether or not diseased women's approaches strengthened their application for aid is for the most part irrelevant. Although the almshouse was in theory supposed to aid the "worthy poor" the city had become so unmanageable that

prostitutes and diseased citizens simply had to be admitted. To this end, I would argue that continual pauper readmissions, especially those of diseased women, served to medicalize the almshouse. Venereal patients consistently manipulated almshouse procedure, and by doing so they helped to shape the later development of the infirmary. Disobedient inmates -most notably venereal women- successfully undermined the original intentions and stipulations of the institution's managers. This group posed such a threat to the existing order within the almshouse they forever changed the original nature of the house as intended by its founders. The almshouse was not originally intended to function primarily as a hospital. Yet as a response to the overwhelming numbers of Philadelphia's sick poor (especially venereal paupers) who were driven to seek medical aid, officials unintentionally endorsed the ad-hoc development of a sophisticated health-care system and the almshouse evolved into the Philadelphia General Hospital.

Prostitutes and diseased almshouse women were also part of a larger culture of poverty that permeated Philadelphia, and they were often an accepted part. In a city that hosted hundreds of establishments for entertainments, prostitutes easily intermingled with the wider pleasure community and they readily found custom. Although prostitutes walked the streets and entered brothels and theatres with one another, they also enjoyed the same leisure pursuits of the community at large. We know about some of those activities because prostitutes often carried out their socializing in a disorderly context and are therefore visible to us. We also know about them because when poverty struck through lack of custom or disease they made their way to the almshouse. However women like Rachel Ward, Mary Carlisle, Lydia Oakman and Sarah Thompson are visible because of their appearance in the institutional record. The sources remain silent for those who did succeed in lucrative brothel adventures and the many more who worked as brothel workers and streetwalkers, or indeed those who occasionally flirted with the trade.

Women arrived together at the almshouse and they also eloped together and in addition, drew upon the support networks provided by their counterparts. Bonds formed in the street were reconstructed inside the almshouse, which helped shape the almshouse experience. In many cases, this often emerged as anti-social behaviour, similar to that played out in the street. Women who sought medical aid in the

almshouse most likely sought acquaintances within the confines of the infirmary. They did this for several reasons: as a way for coping with the emotional pressures of institutional confinement; protecting themselves in the street in an effort to belong to a community; to solicit new custom, and to enjoy the availability of networks of other women in similar situations who could afford advice in the face of health hazards associated with their occupation. Given the paucity of detail it is not possible to reconstruct full biographies. Thus we can only speculate on the finer details of a prostitute's experience such as community bonds and friendship. It is virtually impossible to trace how companionship forged in the polishing room and replicated outside the almshouse played out over a longer period of time.

Prostitutes worked and played together, but they also died together. The scope or capacity for agency had its limitations, especially for those who led precarious lives on the margins and were dependent on public welfare. Women who suffered poverty most intensely, or were advanced in their disease had little room to influence those who administered public medical relief. Yet for all the diseased women who did fit into this category, just as many were able to retain and sometimes mould almshouse rules to continually negotiate medical care on their own terms.

Women who were not so restricted in their choices were in a position where beggars could be choosers in Philadelphia's medical marketplace. Philadelphia offered an array of healthcare outlets. Women could self-treat or seek counsel from one of the many healers who made it their business to offer "specialist" services to those suffering from venereal disease or wanting to deal with unwanted pregnancy. What were the implications of such a varied medical marketplace for diseased women? On the one hand, when this range of remedies and treatments failed, or perhaps when they were unavailable, prostitutes did not hesitate to seek temporary incarceration and treatment within the almshouse, albeit on their own terms. Or, they turned to the almshouse in the first instance.

To what extent were diseased women dependent on wider public charity—clothing, food, fuel—as opposed to medical relief? As we have seen from the evidence on extraordinary seasonal usage for instance, diseased pauper women did seek out regular charity in the face of impoverishment during the harsh winter months. Yet,

there is a flip-side to this. The records also imply that a significant proportion turned up at the almshouse to obtain medicine first and foremost. And for many, after a short spell of therapy, which helped restore their constitutions they either left of their own accord when they felt better, or waited for an official bill of discharge. We know this because the steward and his successor related this kind of important detail. When Mary Carlisle made one of her many appearances it was carefully recorded why she was there. Thus on one occasion she was noted as ‘at present not diseased’. Or when diseased Ann Casper was discharged she was ‘now gone decently clad’.⁸⁵⁸ The steward would state if she was there simply because she was impoverished, even if she was, or had been previously been diseased. Conversely, if a woman sought medical aid in the first instance, she was ‘ill with the venereal’, ‘worse now’ and ‘sorely afflicted’ or ‘now mended’ or ‘relived of the venereal’.

A reconstruction of the polishing room has provided a better understanding as to why many women may actually have selected the almshouse as opposed to other outlets of healthcare in a city known as the crucible of medicine. Botanical remedies appear to have reigned supreme and mercury was certainly not “king” of the almshouse. Broadly speaking they did not sanction the use of mercury compounds unless deemed absolutely necessary. Changes from the late eighteenth century significantly affected Philadelphia’s diseased women. First, the sick were becoming too numerous in the almshouse, therefore it was not financially expedient to keep transferring them to the Pennsylvania Hospital for dangerous mercurial salivation. Second, during the late eighteenth century, the medical profession entered a transitional period, and physicians were embracing gentler therapeutic regimes based on observation. Many almshouse doctors developed their own therapeutic practices drawing upon a medicine chest brimming with a materia medica native to their country. As Nancy McAllister reflects, doctors who pushed the use of plant and vegetable remedies, ‘might have been satisfied to learn of the remedy that became standard for syphilis: penicillin mold was plant based’.⁸⁵⁹

We also have a solid argument that poor Philadelphia women suffering from venereal infection may have been luckier than those who could afford stronger remedies from a

⁸⁵⁸ Mary Carlisle, 28 Jan. 1803; Ann Casper, June 1800, Dockets.

⁸⁵⁹ Nancy McAllister, ‘John Burrows’, 99.

private doctor or a trip to the Pennsylvania Hospital, which indeed seemed to be more characteristic of an institution more likely to kill than cure the patient.⁸⁶⁰ The almshouse infirmary may even have been more therapeutically effective despite the superior quality of care at the Hospital. Crucially, pauper medicine was simply not as concentrated or extreme as that carried out elsewhere. The venereal ward -despite any metaphorical connotations we may take from its identity as the ‘polishing room’- may in fact have saved many of Philadelphia’s sick women from poisoning by the toxic substances usually found in patent remedies or bought straight from the druggist. What’s more, diseased women were often aware of this. Thus, they could, and did make choices. They were after all, as the steward frequently pointed out, ‘new’ or ‘former’ *customers*.

Although patients were often in so much pain they may have been too desperate to care, they nevertheless wanted the best treatment for their bodies with minimum long-term repercussions or bodily scarring. Hearsay and previous use of the almshouse was vital in this respect. Moreover, despite the level of impoverishment in early Philadelphia, not all diseased women were scraping the bottom of the barrel. We choose our preferred local doctor often as a rational decision based on hearsay. So too did many women who embraced infirmary treatment above all others.

We can now repudiate claims that prostitutes were prescribed exclusively with mercury. On the one hand many irregular practitioners who swamped the medical marketplace were mercurialists, that is, they claimed mercury was a specific or antidote for syphilis. Yet doctor and lay person alike were conscious that mercury was not without its dangers.⁸⁶¹ Prostitutes more than any other group beside the medical profession itself, were fully aware that the mercury ‘cure’ could be worse, or at least as bad, as the disease itself. If, as suggested, drastic depletion and mercury was not employed in the almshouse as much or in as great an extent as elsewhere, this would reinforce the suggestion that less harmful treatment was administered here. Thus many women’s venereal sores were cleared up with a short course of relatively mild treatment. Elopement from the almshouse therefore was not merely the consequence

⁸⁶⁰ See Appendix Five for a more detailed analysis of Pennsylvania Hospital therapeutics.

⁸⁶¹ For an illuminating example of lay awareness of mercury’s dangers, see Case 4 from James Anderson’s Casebook, Appendix 3.

of a woman's distaste for her medical treatment.⁸⁶² It is more likely that diseased almshouse women believed a limited and gentler course of medical treatment would have proved less destructive to their bodies.⁸⁶³ They simply made a rational choice to seek almshouse medicine, and once they received the necessary treatment, they took to their heels and returned to their lives often restored to health. Some women who came to the almshouse subsequent to drastic mercurial treatment elsewhere were not so lucky, and for those totally diseased there was little room for choice or any kind. Tomkins has asked of sick paupers who ended up in workhouse infirmaries: 'did patients take their medicines willingly'?⁸⁶⁴ I would suggest they did, and were not coerced into taking their drugs. When patients did escape it was not so prematurely that they did not have time for a good dose of medication. They may not have held much say in what they would be prescribed with, but they did have a fair idea from previous experience and hearsay. Moreover, a diseased woman's main agenda was not simply to exploit resources, and most likely she genuinely wanted to feel better and recover.

Mild remedies may have done little good, but they certainly did less harm than the more highly toxic mercury. Quite simply put, diseased women's actions may well have saved their bodies from mutilation or indeed from perishing. Thomas Sydenham, the seventeenth century 'English Hippocrates' observed that 'many poor people are alive precisely because they could not afford to pay for medical treatment'.⁸⁶⁵

The almshouse infirmary was hardly a retreat for advanced healthcare, its conditions being rudimentary and as Rosenberg claims, 'brutal'.⁸⁶⁶ Nevertheless it provided Philadelphia's indigents with a healthcare system which was clinically superior to many of its counterparts. For the prostitute who witnessed first hand the effects of mercury on her companions, a short stay in the almshouse, which provided food and

⁸⁶² Conversely, Siena argues that elopement was a response to mercury treatment, and when patients could no longer endure the pain of salivation, they took matters into their own hands and fled. Siena, *Venereal Disease*, 131.

⁸⁶³ Of course, for numerous women who were single parents, short-term treatment was imperative.

⁸⁶⁴ Although Tomkins does not enquire into the nature of medicines, she does suggest that admission records imply paupers took their medicines willingly because elopement numbers were low. She also turns to 'cure' rates as exerting an influence on sick paupers using the workhouse infirmaries, thus they repeatedly returned. This is a reasonable assumption. Tomkins, *Urban Poverty*, 121, 140.

⁸⁶⁵ Thomas Sydenham, quote taken from Allen, *Wages of Sin*, 59.

⁸⁶⁶ Rosenberg, *Explaining Epidemics*, 179-80.

personal medical attention with a short course of treatment, no doubt served as an attractive option. This may have motivated a woman's decision to select admission into the almshouse in the first instance.

Appendix 1: Samuel Duffield's Shopping List



Figure 5: Samuel Duffield's Shopping List, Receipt Received June 9th 1785, Sharp & Delaney. Source: Historical Society of Pennsylvania

(The following is a direct translation as far as the legibility of the source will allow hence a question mark if illegible. Transcriptions are in italics)

Philadelphia 5th April 1785
Doct Samuel Duffield
To Sharp and Delaney

Pulv. Cort Peruv	1lb	£17”6	<i>Cinchona/Peruvian Bark</i>
“ Jalapii	4 oz	5 “ -	<i>Jalap</i>
“ Rhei	4 oz	10 ” -	<i>Rhubarb</i>
“ Ipecachuana	4 oz	10 ” -	<i>Ipecac</i>
Tartar Emetic	½ oz	12 ” -	<i>Antimony Potassium Tartrate</i>
Sal Glaub:	?	2 ” -	<i>Glauber’s Salts Sodium Sulphate</i>
Crem:Tartar	?	2” 6	<i>Cream of Tartar Pot Acid Tartrate</i>
Elix Paregoric	?	4 “ 6	<i>Camphorated Tincture of Opium</i>
“ Sod(?) Nitric	4 oz	11	<i>Nitric Acid</i>
Ungt: Basilic: flav	?	3 “ 9	<i>Yellow Basilicon Ointment</i>
“ Cerat.Carbolic (?) ?		3 “ 9	<i>Carbolic Wax Ointment</i>
Flor.Chamamel	½ ?	2 “ -	<i>Chamomile Flowers</i>
Magnesia. Alb	4 oz	4 “ -	<i>Light Magnesium Oxide</i>
Sp:sal.vol.Oleos	4 oz	2 “ 6	<i>Spirit Sal Volatile (Oily)</i>
Camphor	4 oz	3 “ 9	
Ol Ricini ver	1 bottle	12 “ 6	<i>Castor Oil</i>
6 ½ pint wide (mouth?) bottles	1/3	7 “ 6	
2 Do ground stopper Do	2/6	5 “ -	
2 4 oz Ditto	1/6	3 “ -	
5 vials 1/3 2 potts 8d		1 “ 11	
Chest		1 “ 2 “ 6	
		£6 “ 11 “ 2	

Appendix 2: Short Glossary of Medical and Pharmaceutical Terms, Drugs and Chemicals

(Sources: Castleman, *Healing Herbs*, Chapman, *Elements of Therapeutics*; Dymond, *Stutter's Casebook*; Ellis, *Medical Formulary*; Vogel, *American Indian Medicine*; Jackson, *Notebook of Materia Medica* (1895); White and Humphrey, *Pharmacopoeia* (1904).

Note

Although preparations of mercury, antimony, arsenic and zinc were widely used by Western doctors in the eighteenth and nineteenth centuries, botanical medicines found particular favour amongst American physicians. The curative powers of plants tended to lie in the root of the trees and were often made into decoctions for the patient to drink.⁸⁶⁷ Herbs were employed as remedies for all kinds of diseases, but those most pertinent to the treatment of venereal diseases in the almshouse are described below.

The Effects of Mercury on the Body

Regardless of what form or route it enters the body, mercury is eventually metabolized to mercuric chloride- corrosive sublimate-which preferentially binds to the nervous system and kidneys; thus mercury's toxicity is mainly revealed by neuorbehavioural disorders or renal failure. Because mercury is excreted from the body only slowly, over months to years, one can suffer chronic poisoning by taking mercury in regular amounts however small that build up body stores faster than excreted.(source: Hirschhorn, Fieldman and Greaves, 'Abraham Lincoln's Blue Pills', 325).

Medical and Pharmaceutical Terminology and Procedures

Blistering- plasters usually made from yellow wax, mustard and powdered Spanish fly would be applied to the skin to provoke a blister that would expel the poison from the body. A plaster could also be made of soap, often known as the 'poor man's blister'.

Cathartic- stimulates bowel movements

Decoctions- prepared by boiling drugs such as sarsaparilla, guiacum or chamomile flowers. the plant would be boiled with water then strained into drinkable form.

Emetics- produced vomiting

Extracts- obtained by evaporating excess water from a decoction and often made from the leaves of plants.

Frictions- rubbing ointment directly to the skin, often to produce heat. Mercury could be applied this way.

Plaster- a common way to apply external drugs, often caused blistering.

Poultice- a drug applied directly to the skin used to relieve pain

⁸⁶⁷ Manning and Moore, 'Sassafras and Syphilis', 473.

Purgatives- as cathartics or used to puke

Salivation-excessive salivation caused mercury poisoning.

Tinctures- drugs usually in powder form made in a solution of alcohol

Drugs

Aloe- from the West Indies used as purges or decoctions of the leaves, which were gentler in action.

Alum Root- native to North America used as an astringent.

Antimony- a chemical compound used as an ointment, powder or blister. In the almshouse it was usually a potassium compound such as tartar emetic (potassium tartrate). Also used to puke the patient.

Arsenic-a toxic metal

Balsam of Copaiba- an oily resinous substance from the North and South American leguminous tree which was used as a diuretic and orally in the treatment of gonorrhoea. Often given in a liquid decoction with liquorice or myrrh to hide the taste.

Blue Pill/Blue Mass – also called pilula hydrargyri. Commonly made from calomel.

Blue Vitriol- this was applied as a caustic and sprinkled onto the site of venereal warts or ulcers.⁸⁶⁸

Castor Oil- vegetable compound used as a cathartic.

Camphor- a vegetable composition used often in the almshouse combined with opium and made into a pill.

Conium – see hemlock.

Caustic alum- a mild caustic

Calomel- also known as mercurous chloride and was used mostly as a purgative and also produced salivation. It also comprised the blue pill mass of the little blue pill that became popular in the nineteenth century.

Cantharides- Spanish Fly (dried beetles) used to raise blisters.

Chamomile Flowers- extracts from the leaves made into a tonic.

Cinchona- see Peruvian bark

Cicuta- see hemlock

Colombo Root- south American plant.

Corrosive Sublimate- Corrosive sublimate (muriate of mercury/ mercuric chloride) the most powerful of the mercurial forms but least apt to provoke a salivation. Commonly used orally before blue pill made from calomel became popular.

Cinnabar- red mercury ore

Cream of Tarter (potash) - vegetable in origin and familiar now as baking powder. This was used as a purgative.

Elixir of Vitriol- see vitriol

Glauber's Salts- sodium sulphate and used as a saline cathartic.

Guaiacum Wood- a gum resinous substance from the guaiacum tree and native to the West Indies. Used as a syphilis specific from the sixteenth century often in place of mercury. Was ground into a powder then boiled in water, from which a decoction would be obtained. Large doses would induce sweating or excessive salivation, although this plant was harmful. Guaiacum was considered the most time-tested cure for syphilis before mercury was believed to be a specific for syphilis.

Gum Arabic- gummy resinous substance. An ingredient contained in marshmallows. This was one of the largest quantities of drugs ordered by the almshouse apothecary store.

Hemlock- also known as conium or poison hemlock *cicuta* was referred to as water hemlock. Chapman noted the plant's extracts from Europe 'rarely possessed any strength' yet the plant that grew in America could be made in several preparations to 'great perfection'.⁸⁶⁹

Hydr: Fort- strong mercury ointment

Iodide- compounds made from iodine often mixed with sulphate of zinc, potassium or copper.

Ipecac- made from the dried roots of plants from tropical America. This was made into a powder that was used to induce vomiting and was the main ingredient in Dover's Pills.

Jalap- obtained from the roots of a plant from the Mexican Andes. Either used as a laxative, or as a drastic cathartic when used with calomel.

Lead acetate (sugar of lead) - used as an eye wash or applied directly to venereal sores as a mild caustic. A similar lead acetate lotion used on almshouse patients was popular until the mid-twentieth century to treat cuts and bruises. Lead acetate was used in the almshouse for external applications only. Although the salts of lead were

⁸⁶⁹ Chapman, Elements of Therapeutics, 150.

understood to be poisonous, it did not prevent some doctors from employing them internally in the nineteenth century.

Magnesium Oxide- magnesia, white solid mineral. Often infused with barks to make the plant stronger.

Mercury Ointment/Precipitate Rub- applied directly to the site of a lesion or applied to the entire body, often in large quantities and over a period of time to encourage salivation. Potentially curative in small doses although also highly toxic.

Myrrh- a wild plant used as an anti-inflammatory for syphilitics and given as a tincture.

Nitric Acid- a common caustic.

Nitrous Powder-

Oil Rici- see castor oil

Opium- the source of Morphine from the opium poppy, which was usually made into pills from powder or as a tincture. An alkaloid and narcotic, it was routinely dispensed as a pain reliever.

Pil:hydr- a convenient form for administering calomel,

Porter- alcoholic ale

Peruvian bark- also known as cinchona and Jesuit's bark. The drug was obtained from the bark of various cinchona trees, which grew abundantly in the Americas. By the 1820s, the active component of Peruvian bark was isolated as Quinine, with commercial productions following on a wide scale. This was an almshouse favourite.

Quicksilver- mercury.

Rhubarb- a cathartic that was often used with gum Arabic to purge a patient.

Ricini Oleum- also known as castor oil. In Chapman's *Elements of Therapeutics and Materia Medica*, he notes of the substance, 'this grows luxuriously in the United States and is used as a cathartic'.

Salvarsan- also named the magic bullet or 606. Discovered by Paul Ehrlich, the arsenical compound was found to be the most effective cure for syphilis, until the introduction of penicillin.

Sassafras- Chapman described 'the common sassafras of our country' used abundantly as a cure for venereal disease and the plants were made into decoctions and used as tonics.

Sarsaparilla- a root that is native to the Americas and was used widely by American doctors as a cure for syphilis and adjunct for mercurial poisoning.

Seneca ('senega) the leaves were used by American Indians as a cure for snakebite and commonly used as a diuretic.

Tarter Emetic- a harsh medicine used in ointment form as an anti-irritant acted as a sedative or anti-phlogisite

Uva Ursi- also known as bearberry, and the berries are native to north America commonly used in cases of gonorrhoea.

Vitriol- Vitriol elixir and white vitriol were alcohol solutions containing zinc sulphate and were either used as tonics, or external astringents.

Appendix 3: Dr. Anderson's Casebook

The journal left by Dr. James Anderson, a junior almshouse physician from 1804 until 1806 provides rare documentation of actual therapeutics carried out in the almshouse. Anderson's casebook is also informative of the doctor patient relationship.

Case 1

October 18th 1804- William Harvey aged 32 years admitted into the alms-house with an ulcer of a very ugly appearance upon the upper & left side of his nose. It gave him a great deal of very distressing pain...Harvey said it first made its appearance in the year 93 in the form of a pimple with considerable burning and stinging [sic] pains...which had been gradually increasing in every respect for about one year, which was the 15 October 04 against which time it had extended so, as nearly to destroy the sight of his left eye, all the nose, and surrounding... {illeg}....The treatment of this case was in some respect similar to the two foregoing. First...Sol. Arsenik was given. A weakened solution was put in the poultice...a teaspoonful in each...This manner of treatment was continued till the 1st of December...at this time it was thought proper to omit the arsenic...bled 3 times and took several of the Dovers powders...after this time the pain becoming greater the extract Hyoscamus (mild plant-based stimulant) discontinued and the arsenic being again at 60 drops per day...healthy granulations presently made an appearance and the sore contracted above one half in its circumference.. Jan 31st....Doctor Church considered it to be eradicated...Harvey still continued in the ward under the above treatment till 4th March when he eloped and returned to his daily labour in the City.

Case 2

In March 1805, a woman named Alice was 'admitted into the almshouse with a considerable ulcer & inflammation on the upper part of her nose'.⁸⁷⁰ Alice's ulcer was so severe that upon admission the medical attendant presumed it was cancer. Anderson noted, 'she complained of excessive pain darting thro' the circumjacent parts and was considerably debilitated at the same time'. The resident physician Dr. Griffiths claimed her condition was a 'sluffing[sic] ulcer and not a cancer'.⁸⁷¹ The first mode of treatment was an opium pill three times a day, with a purge made from a weak arsenic solution.⁸⁷² Alice's sores rendered her incapacitated for nearly three

⁸⁷⁰ James Anderson, 'A History of Certain Cases taken by the Author during his Residence in the Philadelphia Almshouse, October 1804 to May, 1806', HSP. Alice's surname is illegible, making it difficult to locate her on admission records or the daily occurrence dockets. That she is not traceable in the databases may in fact imply she was not deemed venereal upon admission, as is noted by the reference that her symptoms appeared cancerous.

⁸⁷¹ Sloughing ulcers were commonly associated with tertiary syphilis.

⁸⁷² According to Quétel, arsenics had been employed in the treatment of syphilis since the seventeenth century, and they were clearly used in the almshouse. In Britain arsenicals did not become popular in the treatment of venereal disease till the mid-nineteenth century. Quétel, *History of Syphilis*, 86. Haller suggests that amongst physicians who tended to employ solutions of arsenic, the tendency was to administer it in 'an exacting manner' in 'doses only small enough to cure'. Haller, *Medicine in*

months, and she received treatment in the almshouse that lasted from March till August. For the two weeks, Anderson persevered with the arsenic compound, and as the ulcers and sores lessened in severity he slowly omitted the opium. At this point he also added a solution of one grain conium (hemlock): with this, Alice was also treated with 'Pulv:Galler' when the severity of the sores and ulcers subsided, Alice began complaining of sore limbs and aching bones. Anderson noted that both himself, and the resident physicians were 'led to believe her ulcer originated in the first instance from syphilis'.

Four out of the six patients in Anderson's casebook were treated with weak arsenical compounds. One was treated with a mercurial blister, yet only after a long duration of treatment which did not yield to alternative medicines. While there are only a couple of cases pertaining to ulcers appearing venereal, an examination of different ailments suggest the medical team at the almshouse resorted to botanical prescriptions during the initial stages of treatment.

Case 3

On October 1805...a black aged 40 was admitted...with gangrene of his toes... For which he was treated by taking Opium, Wine and Barks plentifully and an external application of a Charbon poultice. November 7th on my surgical tour I observed the ulcer on the right foot to be more dry than common...to my astonishment I observed tetanic symptoms to a great degree prevailing...to which I immediately ordered him an enema with 60 drops of Laudanum and to sprinkle the sores with Hyd: Nit rub with a warm poultice. As soon as circumstance would permit I made Dr. Catharall acquainted with the case...who recommended the following plan of treatment, he being prescribing surgeon on duty to the almshouse...35 drops of laudanum every hour in a glass of wine...as he can drink Bark in it.

As the case worsened, the patient had mercurial ointment rubbed in his extremities and 'opium mixed with Laudanum'. The date was now 'November 9th' and until now no mercury had been resorted to. The patient was in so much pain that he 'frequently hollows throughout the ward' yet 'unable to articulate'. He subsequently died. What is particularly revealing is the use of barks and nitrous powders on ulcers or sores in the first instance.

Transition, 92-3. There were, according around fifty different preparations of arsenic. The *Medical Formulary* recommended the safest dose to be one drop of arsenic to four grains of opium, being given three times as day. This is the same formula used by the apothecary who mixed the compound for Dr. Anderson, except he gave an even smaller dose with arsenic given once a day, yet the opium three times.

Anderson was by no means totally opposed to salivation as a therapeutic procedure. Indeed when he was ill himself, he salivated his own body with antimonial powder (antimony is a poor conductor of heat therefore could not produce an abrasive salivation). However, he did explain that his preference was the lancet and blistering, rather than salivation. In fact Anderson bled his patients particularly freely. What is particularly revealing is the comparison of procedure employed at the bedside of his private patients from his practice in Chester County with the procedures he used in his hospital rounds. For instance, the doctor seems to have been more liberal with the volume of drugs employed in private practice. In one case of intermittent fever in a child, he noted that ‘in the first place I gave a mercurial cathartic to cure the pneumonia’. His next step is especially noteworthy. Anderson ‘prescribed as well from my observations in the almshouse practice, on the recommendations of Drs. Coxe and Kuhn, ten drops of min[eral] sol[ution] arsenic...combined with a solution of laudanum.’ That arsenic was being used in preference to mercury seems to have been a common practice. This could have been the case simply because it was a cheaper preparation to use. The doctor seems aware of the questionable safety of arsenic. In an ‘Observation’ made at the end of his notes upon the patients cure, he pondered, ‘will arsenic in too large doses not produce a fever and diarrhoea?’⁸⁷³ After further notes on the use of arsenic, he concluded, ‘therefore, great precaution is required in its use and it ought to be given in small doses’. The child he attended had come down with another fever and diarrhoea, and Anderson evidently realised the dose he had prescribed was simply too large. More importantly though- and pertinent to this discussion- his comments suggest that during his almshouse training, he was only accustomed to prescribing small doses. While James Anderson’s casebook is for the most part a collection of ‘interesting cases’ (thus sparse on details of venereal patients), it illuminates some valuable aspects relevant to the treatment of venereal disease in the almshouse.

In his private practice Anderson salivated without mercury, perhaps recalling his ward the lectures of his predecessor at the almshouse John Redman Coxe, who contended

⁸⁷³ James Anderson, Notes taken by the Author from his Country Practice, Charlestonship, Chester County, 1806.

‘disagreeable sores are produced by mercury...the influence of mercury is very extensive over the whole body’.

Case 4

In Anderson’s journal taken from his practice in Maple Township he attends as a case that is particularly illustrative of both a doctor’s and patient’s acknowledgment of the toxic effect of mercury, and indeed the patient appears terrified at the idea of mercurial salivation. In a case titled ‘Salivation caused by Valerium’ Anderson visited a patient who displayed a ‘frequent and hard pain in the head and back &c But particularly confined to the thorax some suppression of bile and irritable stomach’. ⁸⁷⁴ The doctor ‘requested him to take the Nitrous powders as freely as the stomach could bear, and continued till he was 7 times freely bled’. The following week, Anderson ‘ordered him a Decoct. of valerium to be taken in small quantities thro the day’. According to the doctor ‘it answered well’ and two days later Anderson returned to check on his patient. However, to the doctor’s astonishment,

when I saw him he had been complaining much to his friends...and then complained to me for salivating him, alleging he had made his sentiments known to me on mercury when I first saw him and he was now spitting to the amount of two quarts per day.

Anderson was taken aback that his patient ‘seemed a good deal irritated’ that his doctor may have tricked him. Upon an examination, the doctor ‘made clear it was not a mercurial salivation...I then reconciled him by a correct statement of the case’. The doctor proved there was ‘no mercury on the breath...and the teeth were firm in their sockets’. In fact, somewhat pleased with the results of his treatment plan, Anderson noted that his patient ‘had a *good* recovery’. Thus, we see the general public’s fear of mercury treatment. If a patient living in a remote area could be so aware of the dangers of mercurial procedures and heroic depletion, diseased women more than any other group would almost certainly have appreciated the full horror that could be affected by mercurial salivation.

James Anderson’s journal also points toward patient participation still being an important aspect in American doctor patient relationships. In his private practice we

⁸⁷⁴ James Anderson, Notes of Sundrie Cases either Medical or Surgical for the Year 1807, HSP.

see a sharp distinction in the doctor patient relationship between private practice and the hospital exchange. In case 2, the hospital patient still assumes a role in narrating her medical history and is thus given a platform to delineate her diagnosis. Alice hid her earlier syphilitic illness and vocalised her own diagnosis. Thus, Alice described her ulcer as cancerous and did not make any mention of previous venereal symptoms. Yet, Anderson noted in his observations of the patient that the character of her sores as they changed under treatment were suggestive of an old syphilitic ulcer. Yet, the patient made no mention of previous venereal complaints. Although doctors did recognize the patient's perspective, this stopped short of actual method of treatment. Conversely, in case 4, the patient is given considerable space to articulate his chosen methods of treatment, and makes clear what type of therapy he will not accept. Moreover, the patient freely contests the practice of his doctor, and accuses Anderson of duping him. This exemplifies distrust of the regular medical profession in general.

Appendix 4: Pennsylvania Hospital Therapeutics

Turning to the records from the more prestigious Pennsylvania Hospital, we can compare therapeutics in more detail, and patient case files left by physician William Martin from 1785 to 1786 prove illuminating. Thomas Young was admitted to the Hospital with ‘Scrofula and Gonorrhoea’. On the patient’s first day he was prescribed with extract of cicuta ‘for the ulcer’ which was followed with injections of opium combined with six grains of calomel with jalap. This was likely carried to salivation, and the patient was released six weeks later deemed cured.⁸⁷⁵ The Pennsylvania Hospital records do not lend themselves to easy analysis with respect to venereal patients, this being the sole record recording treatment of a venereal complaint. Case histories were generally kept during this period simply because they were deemed atypical cases. However, it was the nature of an illness that was considered uncharacteristic rather than therapeutic practice.

Amongst the sparse patient histories lying in the Pennsylvania Hospital archives is a casebook, more specifically, a ‘collection’ of ‘interesting and instructive cases’ in which different doctors made somewhat lengthy entries.⁸⁷⁶ Digging deeper into this source reveals therapeutics that may be regarded as representative of the hospital. While cases of actual venereal complaints are not included, clues are embedded within the source recorded by a number of different doctors. Therefore it provides a window into how this hospital for the ‘worthy’ poor medically treated its patients. All told, they point towards salivation as standard practice. In January 1801, a merchant’s clerk William Poole ‘was admitted into the Hospital ... with Consumption’. On arrival, Poole was ‘emaciated and had frequent chills and constant sweats’. The attending doctor noted that ‘Dr. Rush...ordered the mercurial ointment to be rubbed into his sides in order to excite a salivation’. So delighted was Rush with the result of this abrasive treatment, he was ‘highly gratified to hear him [the patient] complain of swelled gums and great pains in his teeth’. Poole was ‘discharged cured on second of May in the same year’. The case was in fact titled ‘the Salutory Effects of Mercury in

⁸⁷⁵ William Martin, Prescriptions of Cases in the Pennsylvania Hospital, Medical Notes, 1785-1786, HSP.

⁸⁷⁶ It seems clear almshouse patients that were moved to the Pennsylvania Hospital were those cases deemed more worthy of note or out of the ordinary, rather than mundane cases of venereal diseases. According to Charles Caldwell, who began his training at the almshouse before moving to the Pennsylvania Hospital, as a student, he would occasionally visit the Pennsylvania Hospital. After Benjamin Rush had finished his tour of the wards, Caldwell ‘entered and examined most cases as I deemed most interesting and instructive’. That a book of interesting cases should be kept to this effect naturally follows. Charles Caldwell, *Autobiography*, 265.

Consumption'.⁸⁷⁷ A further illuminating case was recorded in November 1803, when a twenty-four-year-old sailor John Brown was treated for 'Shcirrus [of the] Testis' (a cancerous or hardened tumour). Brown had been suffering from this affliction for six months, being in and out of the Hospital, during which time he had been 'repeatedly bled, and salivated...[with] a variety of local applications such as blisters, the mercurial ointment...all without benefit'. When Dr. Physick stepped in however, he abandoned these practices "thinking that the swelling might be reduced by the application of constant and moderate degrees of pressure to the testis' by 'constructing a bag' to do so. Consequently, 'the use of the bag a few days longer completed a Cure'.⁸⁷⁸

A case of Tetanus perfectly illustrates the unhappy consequence of drastic therapeutics at the Pennsylvania Hospital. The unfortunate victim was fourteen-year old Elijah Dunn who was 'admitted into the Hospital for an injury received from a fall from a horse'. Initially his wounds appeared slight and he was prescribed Bark and elixir vitriol, and the wounds dressed with 'poultices sprinkled with laudanum'. However, complications arose and the young patient began experiencing spasmodic pains, frequent convulsions and sores appeared on his body. After a regimen that included mustard poultices, opium, laudanum and tinctures of cantharides.⁸⁷⁹ there was little change in the young patient. On one morning alone, the patient was prescribed 400 drops of laudanum and as much cantharides' until he 'grew comatose'. After the 'sore became more inflamed...Dr. Rush turned up at this period'. A similar regimen was continued, yet now also 'to rub in...strong mercurial ointment into the thigh every hour and five grains of calomel every two hours into the gums'. This was indeed an abrasive course of treatment, and it was later noted by the attending doctor

⁸⁷⁷ Collection of Hospital Cases, Vol. 1, 1803, Pennsylvania Hospital Archives, Historical Collections, Philadelphia. Case 1.

⁸⁷⁸ Recall that Dr. Physick was previously an almshouse resident.

⁸⁷⁹ This is a description of blistering which involved 'placing mustard plasters, Spanish Fly (cantharides), or some other substance (such as mercury) to the skin with the intention of causing a second-degree burn'. According to Duffy, the blisters frequently became infected, and the resulting suppuration was assumed to be the poisons or 'bad humour' being drawn from the body. Thus he explains, blistering 'was scarcely a mild form of treatment, but it was made more painful by many physicians, particularly in the South and West, who heeded the advice that the sicker the patient, the more drastic the therapy'. Duffy, *Humors*, 73. As we have already seen, Nathaniel Chapman deplored the drastic methods of Southern physicians. The Tinctures of Cantharides being referred to was also remarked upon by Chapman in his lectures; 'I have tried it and never derived any benefit from it...I have discontinued this practice and will not recommend it to you', 'Dr. Chapman's Notes, 1810', Vol. 1.

recording this case, that new eruptions had formed ‘since yesterday’ when Rush ordered mercurial treatment. Thus, the patient’s ‘gums seem...affected by the mercury...he has taken half an ounce of calomel and nearly half a pound of the ointment which has been faithfully applied!’ Following this, although the calomel was omitted, ‘the mercurial frictions continued’. Elijah Dunn was clearly now suffering the effects of acute mercury poisoning, the convulsions became more frequent and ‘his face becoming very livid’. The patient died ‘22 days after admission’. An autopsy was carried out on young body, and the dissection report stated: ‘in the course of the disease (22 days) the patient took 2400 drops of tinctures of cantharides, about 2000 tinctures of opium...and nearly three Gallons of Wine’. This was on top of the heroic quantities of mercurial preparations.⁸⁸⁰ It would seem patients being treated the Pennsylvania Hospital were subjected to abrasive therapy to the point of death. And it is not a surprise that Benjamin Rush played a significant role in this case.

⁸⁸⁰ Collection of Cases, 17-24.

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