

**HEALTH ISSUES AND MEDICAL CARE IN
THE OHIO PENITENTIARY: 1833-1907**

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Abstract

Throughout the 19th Century, a large state penitentiary in Columbus, Ohio housed hundreds of male and female inmates from around the nation. As with any institution, medical care and the health of the prisoners were of concern to Ohio Penitentiary officials. Utilizing annual reports written by prison officials to the Ohio Governor over a 74 year time span, this article explores prominent inmate health care issues of the times such as overall health, women's health, illnesses treated, mental health, and the infectious and chronic illnesses that were treated. Ultimately, those in charge of inmate medical concerns were products of their times, with viewpoints and actions tempered by medical ideologies as well as political and economic motivations. The health issues of concern and the medical care provided to inmates are also rooted in these discourses and shed light on penitentiary medical care as well as insight into Ohio and national United States medical history.

Keywords: penitentiary physicians, inmate health, institutional health care, American medical history

Introduction

Ohio, once part of the "West", rapidly became a center for settlement and transportation as America continued to expand. Though not of the geographical size or population density of larger cities such as New York, Ohio cities such as Cincinnati, Cleveland and Columbus became hubs for industrialization and transportation even as the surrounding rural Ohio regions contributed significantly to the agricultural production of the United States.

Columbus became the capital city of Ohio in 1816. Around the same time, the first buildings of what would become a large state penitentiary were located along the waterfront. Growing into one of the most significant penal institutions in the nation, the Ohio Penitentiary would occupy a central place in Ohio history for the next century. Located on the corner of Spring Street near the Scioto River, the institution eventually covered 25 acres and held thousands of prisoners. Early in its history, penitentiary officials recognized that inmate health should be a primary concern in the day-to-day operations. A physician was appointed and his reports began to be included in the annual reports to the Governor. These documents included aggregate information about the health of all incarcerated inmates. Because these inmates were drawn from all over the country, examining their health and health care opens a window into the medical history of diseases present in the United States from 1833 to around the turn of the century. This project's goal is to examine the state of health within the Penitentiary walls as it was reported by the board of managers, warden and prison physician. Primary investigative questions encompassed by this project are as follows. What infectious illnesses were being treated? What chronic diseases were present? What were the most common causes of mortality within the prison? How were female health issues addressed? How was mental health assessed and treated? Did prison medical care reflect trends in American medical history? To answer these questions, this paper analyzes quantitative and qualitative data to illuminate morbidity and mortality patterns within the Ohio Penitentiary for a 74 year period between 1833 and 1907, ultimately addressing prison medical care in the late 19th Century.

Materials & Methods

The materials for this project originated from several Ohio Penitentiary records. The first source of data came from yearly reports issued by the officers of the Ohio Penitentiary to the Governor of Ohio for the years 1833-1907. Each report contained a statement from the heads of the departments in the institution regarding the state of their area of supervision (e.g. chaplain, physician, and gas works supervisor). This paper specifically draws on the annual reports of the board of managers, warden and physician. The basic report format was similar across years; however, the internal configuration of every section was left to the discretion of the prison official. Typically, each physician's report included a written statement of the inmates' health, deaths in the prison or any other issues he wished to be present in the official record. Some exceptions to this were the reports from the years 1837-1839, where only charts were included by the physician with no written report. Usually incorporated into the report were summaries of illnesses treated during the year. Some reports list by month the numbers of prisoners treated for specific illnesses, diseases, etc. while others only list yearly totals for the diseases. Occasionally, a reporting physician became disillusioned by this record keeping task and refused to include such lists, questioning their usefulness.¹

These variations as well as variation in the fiscal year² and the number of months reported³ necessitated only using part of the available data in order to incorporate as many years as possible into the study. Additional summary data about the inmates in the penitentiary are drawn from a large database constructed from the prison register, a record book which held information on each inmate and was recorded by the institution clerk as the inmates entered into the Ohio Penitentiary.⁴

Temporal changes in medical terminology are evident in the reports as American medical practice changed over the years encompassed by the study and some terms are completely different from those in modern medical practice. For the purposes of this project, only certain terms identifiable as associated with or directly referring to the specific illnesses of interest were used in the analysis. Other terms in the reports probably refer to symptoms related to the various illnesses discussed in this paper. Some terminology of the times seemed similar but in fact reflected different illnesses. For example, typhus fever refers to a different organism than the bacteria which causes typhoid fever, but sometimes the spelling of the two illnesses was similar.⁵ The authors have chosen to err on the side of caution in interpreting the terminology. This leads to a more conservative estimation of the prevalence of disease in the penitentiary rather than the potential for overestimation that could result from inclusion of diseases erroneously associated with a particular disease.

Brief History and Structure of the Ohio Penitentiary

The Ohio Penitentiary first opened its doors in 1815 as little more than a few buildings surrounded by a stockade, about a mile from the 1830s location. At that time, the prison was only 2,160 square feet in area.⁶ For comparison, this area is roughly equivalent to a moderately sized house in today's standards. By 1832, overcrowding necessitated a move to the Spring Street site on the east bank of the Scioto River. After study of other contemporary prison designs, the Ohio Penitentiary was built along the Auburn style of prison design, a system in which cells are built in a tier design.⁷ Work on the new penitentiary was halted temporarily in July of 1833 by an outbreak of cholera among the prisoners; at least 100 inmates became

infected and 11 died.⁸ Work resumed in September, 1833 after the epidemic had concluded. This would not be the last time cholera would impact the penitentiary.

By 1837 the site was nearly complete and the first 148 prisoners who occupied the penitentiary had to finish the construction. This new prison was 25 acres in total area, with cell blocks 5 stories high and holding 1630 cells.⁹ The main cell blocks housed male inmates, while the female department was a separate area with three stories, the third floor of which comprised the cells. Over the succeeding seventy years, rapid inmate population expansion resulted from the Ohio penitentiary attempting to meet local as well as state and federal demands to incarcerate increasing numbers of individuals. Within a few years the prison included more cell blocks, a hospital, kitchen, bakery, a school, a printing and binding area, a state shop and numerous other workshop areas. The workshop areas occupied more of the space inside the walls than the living areas for the inmates and reflected the correctional attitudes of the time: hard work and spare living was the way to reformation of the convicted criminal.

The layout encompassed a row of cells along one wall, with workshops and other buildings located in a wide yard behind the cell blocks. As the Ohio penitentiary grew, the cell blocks extended along two walls in an 'L' shape. The female department was located outside the main wall, as were the stables and a storehouse. A single building served as the hospital and the kitchen; the hospital was located on the third floor, above the kitchen. This single floor hospital included wards for inmates needing hospital care, treatment areas, and a dispensary.¹⁰ The chapel and warden's office were set into a central grassy area. This central grassy area

served as an exercise area for the inmates. Sewer and drainage pipes ran through the penitentiary, including a main sewage pipe which ran through two cell blocks.

By the late 1880s, there were five main cell blocks. Five stories high, four cell blocks contained 70 cells each, and one cell block contained 46. Though 1890s plans of the Ohio Penitentiary delineate individual cells for women and mentally ill convicts, in earlier decades the reports described other arrangements.¹¹ Until 1864, insane convicts were kept wherever space allowed and treatment and facilities were a constant problem for penitentiary officials. Insane inmates were eventually separated from the population at large, though initially they were kept in cells next to other inmates. The ward designed for insane inmates shows 12 cells (with a likely capacity of 24 individuals). Reports showed that as many as 30 insane inmates were treated at one time, with numbers as high as 66 listed as treated for the year 1893.¹² In spite of the construction of an Asylum by the 1860s within the Penitentiary walls, its small size ultimately precluded the adequate housing and treatment of the insane.

Prisoner intake into the institution rose continually throughout the study period. The total number of prisoners to pass through the door went from 201 inmates in 1834 to a high of 3406 in 1897, after which the numbers decreased slightly. The prison became more and more crowded (Figure 1) while no substantial changes in the layout were made. At various times inmates were bunked in large rooms converted from use as workshops into prisoner dormitories, most notably during the 1849 cholera epidemic. After 1897, prisoner intake numbers declined until 1907, when a (comparatively) lower 2,234 inmates were moved through the Penitentiary.

Popular sentiment of the times commonly viewed the penitentiary and its officers as agents of rehabilitation. Through the years this goal would not change substantially although certain time periods focused more on punishment rather than rehabilitation. The Warden and his assistants were responsible for prison discipline and punishment of the inmates. Until a female matron was hired in 1845, female inmates were left largely to their own devices. The matron reported to the Warden and directed the rehabilitation, discipline and labor of the female inmates. Prison rules mandated that all inmates refrain from talking with one another at all times except on holidays. For infractions against the rules, solitary confinement was the most commonly dispensed mode of punishment. Other punishments described in a variety of prison related documents include the 'hummingbird' and 'ducking.'¹³ Through the study period, the penitentiary regularly employed a person (always a man) directly responsible for the moral rehabilitation of the prisoners. This individual's title started out as 'moral instructor.' This job eventually merged with religious instruction and became part of the chaplain's role. Also falling under the chaplain's purview was the library and to some extent, collecting data about the inmates.

Physicians

Between 1835 and 1907 the Ohio Penitentiary employed nearly 30 different physicians appointed to the care of the inmates (Table 1).¹⁴ During the early years of the institution, there was no official position of physician; rather, doctors were brought in from the surrounding areas as they were needed. Just prior to the move to the new Spring Street site, prison officials asked the Ohio State Legislature for a regular salaried physician position. Little information exists as to how the physician was appointed; likely it was a political appointment.¹⁵ Doctors

were not resident at the penitentiary. In the first decades of the Ohio Penitentiary, the physician appointment changed occupants frequently. In the mid to late 19th century, the appointment stabilized and became more long term. From 1833 to 1856 there were 13 doctors in 22 years; compared with 17 doctors between 1857 and 1907, a span of 50 years. On average, a physician worked at the penitentiary for 2.4 years at a stretch, with several physicians in position for as little as part of a year. Others, notably Davis Halderman, Norman Gay and J.W. Clemner worked for stretches as long as 4 (Clemner), 5 (Halderman) and 6 years (Gay).¹⁶ Two physicians were appointment more than once: William Trevitt and Norman Gay. The 1868 report details the duties of the physician. We have assumed that every physician through the study period performed his duties under the same rules as a comparison of the rules throughout the years showed no significant changes.¹⁷

The doctor was required to visit the Penitentiary every day at least once, and examine every sick or complaining prisoner, prescribing for their treatment as necessary. The treatments included, but were not limited to: overseeing distribution of medication, performing surgical operations and approving the diet of sick inmates. The physician was also charged with record keeping, which according to the reports consisted of keeping track of those inmates who died as well as maintaining a book called the 'Hospital Registry' which served as the list of sick or complaining inmates.¹⁸ From these records came the annual reports mentioned above. Additionally, the physician was responsible for keeping a list of items needed in the medical care of inmates and asking the Warden for the purchase of such items as he saw fit.¹⁹ Therefore, the position of prison physician was one which included clinical work with patients as well as administration of the medical and supply records.

Though he was in charge of health care, the physician was not the only individual caring for the inmates. At any one time, the physician may have had one to three assistants, sometimes physicians in training. However, there is a complete dearth of information regarding these men and their roles except for occasional listing of their names and an expression of gratitude from the physician-in-charge. One source indicated a 'day' and 'night' physician and stated that these men were at the prison hospital for their shifts²⁰. Nurses, often recruited from the male inmate population and trained, helped care for the sick in the hospital ward.

Physician Reports

At the close of the fiscal year the penitentiary department heads, including the physician, compiled data into an annual report. These reports were prefaced by statements from the board of managers and the warden and issued to the governor of the state. Considerable variation exists within the reports as there was no standardization. Physicians could choose any format and include any information they wished. As stated before, common elements within the reports were a written statement and summary tables with various forms of aggregate data. Sometimes the physician statements were brief, to the point and focused on inmate health. Other years, the physician utilized the report as a vehicle to discuss issues he deemed important. One such report was issued by prison physician C.B. Ferrell who discussed what he felt was the complete lack of usefulness of record keeping by the previous prison physician (W.H Drury). Dr. Ferrell believed that such records were useless because they were not consistently kept and that many inmates lied about their personal histories, thus rendering the task even more odious²¹. Another physician, J.W. Clemner, issued his report in 1887 on the

manner by which prisoners were executed and made a case for the use of electricity, not hanging, as the method of legal execution.²²

Health

Inmate health was viewed through a number of different lenses by penitentiary officials. Though the structure of the reports varied somewhat over the 74 year study period, several themes persist which demonstrate that the penitentiary physicians were very much products of American culture and medical system. The reports issued by the physicians and wardens expressed their concern for inmate health as something required “by the laws of humanity as well as good policy.”²³ The duty of officials was ostensibly to “do all in our power both to prevent disease and alleviate the sufferings of those unfortunate persons thus deprived of the sympathy and aid of their relatives and friends.”²⁴ Prison officials, therefore, were responsible for the physical, mental and moral health of hundreds of inmates. Physicians conducted cursory examinations of every inmate as they entered the penitentiary and noted overall health and health history. Morning sick call, mandated by prison regulations, ensured that inmates who self-identified as ill would be seen a physician. Regulations required twice daily visits by the physician, more if the situation required. Prison doctors were not resident at the institution and each had his own practice outside the walls. Inmates likely had more contact with the assistant physicians and nurses than with the prison physician himself.

Prison officials attributed inmate illness and death to the weak or broken down ‘constitution’ that the prisoners brought with them upon entering the Ohio Penitentiary. This poor constitution was linked to an intemperate lifestyle; one of “vice & dissipation.”²⁵ More than one physician utilized this phrase in particular to refer to the inmates’ lifestyles. There

was some recognition by the physicians that “Not all men were of this class, but ills of the institution spring mainly from this source.”²⁶ Dr. Halderman, who held the physician position for most of the 1870s, believed that the inmates were of an “inferior class.”²⁷

An often alluded-to belief was sometimes explicitly stated in the reports: physical health, more than just a result of poor lifestyle choices, was a reflection of moral health. Dr. D.R. Montgomery stated that many of the inmates had been “brought up in sin and have inherited disease as well as acquired it.”²⁸ Physicians also believed that mental constitution, separate from moral or physical constitution, played a role in who would fall ill or recover, especially during times when disease was rampant. One of the doctors noted that during the cholera outbreak of 1849 that those who were more “cool, philosophic, and determined” held up better in the face of the disease than those who were “timid and irresolute.”²⁹ These beliefs mixed current ideas of health and medical care with current thought in criminology and morality and represented the attempts of penitentiary physicians to reconcile changing notions of science with everyday practice.

Aggregate health

Except for unusual cases, the structure of the reports did not allow for individual inmate health reports. In their reports, many physicians referred to “the health of the Institution”; this was always associated with a characterization as to its nature. Examples include ‘good’, ‘not so good as the year preceding’, and ‘not different from the country generally’.³⁰ Health in this sense became a totality, a summary of individual inmate illness and wellness experiences. This concept of the health as something aggregate and belonging to the Institution instead of to individuals is one that first takes hold during the 1850s and probably was reflection of societal

beliefs of the times. Nearly identical phrases or similar concepts are utilized throughout the remainder of the study period. The ubiquitous use of the phrase points to a larger concept held by the physicians and was more than simply a turn of phrase. They were not so much responsible for individual patients but for the health of the monolith known as the Ohio Penitentiary.

As stewards of a greater responsibility for a collective inmate body, the physicians often voiced unease with factors which they believed negatively impacted on overall inmate health. Nearly every physician devoted some space in the reports to either commending the warden for the good sanitation of the Institution or pointing out areas in which sanitary improvements were needed. Even before the concepts of fomites was widely accepted or understood, Dr. J.W. Hamilton described 'wooden night soil buckets' which became saturated with waste and were perceived as a potential source for disease.³¹ His recommendation was to purchase metal buckets that were easier to clean. The cleanliness of the prison grounds, hospital, workshops, etc. was high on the priority list for prison officials. Large efforts were expended to keep the penitentiary 'sanitary.' Sanitation was viewed as a preventative measure against innumerable diseases, especially cholera. Most of the associated labor was probably done by the inmates themselves, as chores ranging from whitewashing fences and buildings to dishwashing were noted in the reports. While surface contamination was thought to harbor disease, personal hygiene was not considered as important a factor in disease prevention in the penitentiary. Individual inmate hygiene was largely neglected and only a small communal bathing facility was provided.

Prisoner diet also began to concern the physicians. On the whole, physicians commended the warden for the abundant, good 'solid' food provided to the inmates.³² Only occasionally did the physician assert his limited authority to recommend changes to inmate diet. One account of a summer bout with an unknown illness among the inmates led the physician to suggest substituting wheat flour for rye, which the doctor stated solved the issue. Scurvy found its way into the written summaries for the first time during the 1850s, though it was listed in the tables of illnesses treated as early as 1837. In supplement to his 1854 report, prison physician Dr. De Lezinski criticized prison officials for providing an inadequate diet. He offered suggestions for improving nutrition and warding off further scurvy outbreaks. It is logical to assume that the inmates' diet was commonly of a fairly poor nature, despite official reports to the contrary. An eye toward the prison's finances may have led wardens to cost-cut wherever possible, and certainly foodstuffs would have been an excellent target for penny-pinching.³³ In spite of this, entwined with concerns about poor diet and poor health were notions that a good diet combined with intensive work was good for inmates.³⁴ As part of their time in the Ohio Penitentiary, inmates were required to work either in the workshops or outside the prison on a number of contracts.

Included in some of the reports was an accounting of (work) days lost to illness, demonstrating that perhaps the interest in the collective inmate health did not stem from a purely altruistic viewpoint. Rather, since the inmates were hired out on labor contracts (both state and private), they were seen as a source of income for the penitentiary. Any impacts to collective inmate health could ultimately affect the institution's bottom line. If inmates were too ill or too poorly nourished, they could not work effectively. This occurred most dramatically

in 1833 during a cholera epidemic. So many inmates fell ill that the penitentiary workshops had to shut down and no inmates could be sent out on other labor contracts, thus costing the penitentiary income. Similar instances in which illness slowed or ceased work were repeated on a more minor scale over the decades.

Facilities

While new buildings or cellblocks were sometimes added over the decades, Ohio Penitentiary facilities did not undergo any significant renovations during the study period. Workshops, the hospital, kitchen and other buildings were aging. By the late 1800s, the current incarnation of the prison was over 50 years old. The cell design and layout were from the 1830s. Its cells were small, measured at 7'x3.5'x6'9'.³⁵ Though the prison officials decried this size, it did not substantially change over the next decades. The prison population increased over time, further impacting the aging facilities (Figure 1). In July of 1874, for example, 1037 men were imprisoned in the penitentiary, possibly leaving only 13 cells vacant.

Bad ventilation was a constant theme as the Ohio Penitentiary began to age. During the 18th and early 19th centuries, many illnesses were believed to originate in the air, especially bad air or air that was 'miasmatic.' Disease and death in the penitentiary were often ascribed in part to poorly ventilated, small, crowded cells which allowed the bad air to further stagnate. The poor ventilation and possible solutions were mentioned by several physicians, including Dr. Hamilton who lauded the 'efficiency of the Warden' for the excellent ventilation.³⁶ Yet later in his report, Hamilton asked that the 'poor' ventilation be improved through the addition of windows in various areas of the prison. Other aspects of prison facilities were addressed as potential disease causing areas. The main sewer line ran throughout the prison, including

underneath two cell blocks. As time passed and the line aged, leaks in the system began to increase fears that the poor sewer might cause disease outbreaks. Occasionally prison doctors asked that a new sewer system be installed, a costly and laborious proposition.

Women's Health

The brief statements about women's health do more to highlight treatment of women in the penitentiary than to offer insight on female health issues. For the most part, it appears that women and women's health issues were sidelined. During Ohio Penitentiary history, the women's ward was sometimes located outside the walls of the penitentiary, thus physically removing the female prisoners from their male counterparts. The women were similarly removed from the day-to-day running of the penitentiary, including health issues. The matron assumed full responsibility for the female inmates and her purview ranged from labor to behavior to health issues. Occasionally in her reports, the matron mentioned health issues associated with her charges, which were most often common psychiatric illnesses of the times. Several matrons' reports mention a birth and in one case, a woman was allowed to bring her infant into the prison with her.³⁷ If female deaths occurred during the year, they were most often reported in the matrons' report and not included in the physician's report or his death count.³⁸ One matron's report states "no infant children remain in prison", which brings up the question of how often this was allowed, and if older children were also allowed to accompany their mothers into the penitentiary.³⁹ No records have been found to date to shed light on this interesting issue.

Illnesses treated

Consistently, the single two most common medical complaints of the inmates were diarrhea and dysentery.⁴⁰ This trend began in the 1830s and lasted until the 1890s; for nearly 60 years, inmates were at highest risk in the penitentiary from diarrhea and dysentery. In modern medical parlance, these are not 'diseases' as they are symptoms of diseases. The records did not contain many hints about the possible causation of diarrhea and dysentery; however speculation can link these two illnesses to several factors. Likely poor sanitation and the inadequate sewage system within the walls exposed inmates to higher levels of bacteria, especially as the prison began to become overcrowded. In the early years of the institution, the night soil buckets were made of wood, not metal.⁴¹ This would have undoubtedly led to unsanitary conditions. The prison routine was such that every morning, inmates emerged from their cells with their drinking cups and night soil buckets in one hand, the other hand placed on the inmate in front of them as they marched in lockstep to the morning meal.⁴² Certainly, diarrhea and dysentery can be physical responses to a wide array of physical illnesses, including cholera. The high levels of diarrhea and dysentery could also be linked to already undoubtedly stressed immune systems of many prisoners, triggered by differing causes, but treated and listed as the same by prison physicians. Diarrheal and dysenteric illnesses can also be linked to poor diet.

A different trend emerged in the 1890s. During this decade, the most common medical issue inmates underwent treatment for were various wounds. Wounds were listed as one of the major illnesses treated in the '70s and '80s but it was not until the 1890s that wounds superseded diarrhea and dysentery as the most common medical issue. Although not

categorized as an 'illness' by medical practitioners today, physicians at that time included trauma in the list of illnesses treated. This was probably because each required treatment and to the penitentiary physicians, such a distinction was merely semantic. In all decades, wounds were listed by type: contused, incised, lacerated and puncture. Separated out were gunshot wounds, wounds occurring from accidents in the workshops and any wounds thought to be notable (e.g. contused wound of abdomen).⁴³ Since only a brief description was put forth in the reports, it is nearly impossible to judge the severity of the wounds. Most wounds could be assumed to be fairly minor, because if a wound was major or progressed into gangrene or even death, it was listed as such in the reports.⁴⁴ (Today gangrene would be categorized as a secondary medical problem as a consequence of trauma). Some evidence in the reports pointed to inmates deliberately injuring themselves.⁴⁵ However, the reasons for self-injury remain unclear. Certainly, avoidance of work would be a likely reason why an inmate might injure his- or herself; though the 1883 physician stated "Some gave one reason for doing so and others gave other excuses." Psychological issues might have been involved, but there were no usually indications of this in the reports. Inter-inmate conflict was rarely addressed unless it was severe, and the extent to which such conflicts factored into wounds treated is completely unknown. By the 1900s, La Grippe (influenza) and tuberculosis became the top medical concerns treated in the penitentiary (tuberculosis was already among the top causes of death and had been for many decades).

Infectious Illness

Because so little of what caused disease was understood by 19th century physicians, disease in general and infectious disease in particular caused much dismay.⁴⁶ Illnesses such as

cholera, smallpox and typhoid fever were subjects of great fear for physicians and lay people alike. In fact, it may have been the 1833 cholera epidemic that spurred the request of the warden for a full-time penitentiary physician, as 100 cases of cholera were reported in the penitentiary during the outbreak. All labor ceased and 11 inmates died, which caused prison officials to raise the cry for a staffed prison hospital. Through the years, what is now known as infectious illness occupied much of the penitentiary physician's attention. Fear of large scale outbreaks drove physician requests to the Governor for better facilities, including a place to quarantine ill inmates. Their reports often focused on measures (or lack thereof) to prevent infectious illness. The 1848 narrative was a stern warning to prison officials about Asiatic cholera, which was in its earliest epidemic stages during that year. Dr. Lathrop's warnings did not prevent infection; and in 1849 cholera struck the prison, killing 116 inmates.

The reports early in the 1850's show an Institution still reeling from the 1849 cholera epidemic, especially the 1850 report which still made numerous references to the events of 1849. In 1850, all inmates received smallpox vaccinations to address possible infection by new inmates from Cincinnati, where the disease was then epidemic. This was the first time vaccinations were mentioned in the reports, though they may have been given prior to this period.⁴⁷ Subsequently, vaccination became a routine part of the physician's job, and occasionally, the doctor not only vaccinated all incoming prisoners but re-vaccinated all incumbent inmates.⁴⁸

By the late 1860s, tuberculosis began to weigh on the physicians as the death toll from the disease continued to rise. "Scrofula seems to develop in every case that had been afflicted with it prior to confinement in the prison and in a few cases it has made its appearance in

persons who were free from it prior to their imprisonment.”⁴⁹ From this time on, tuberculosis was to be a constant concern to the Ohio Penitentiary physicians, warden and even the board of managers/directors. The physician mentioned the effects of this chronic infectious illness in nearly all subsequent reports. Poor ventilation was blamed for fostering tuberculosis: “blood becomes vitiated and digestion imperfect, supplying the elements for tubercular disease” due to inadequate ventilation.⁵⁰ At least one report acknowledged that some inmates contracted tuberculosis while incarcerated; it is interesting to note that this statement originates with the Warden and not with the physician of that year.⁵¹ In fact, the physician stated that “most of the prisoners were diseased men before being sent to the penitentiary—with depraved habits of every kind.”⁵² In 1904, the prison was inspected by the state board of health due to the concerns with the high death rate due to tuberculosis over the preceding 10 year period (125 inmates were recorded as dying from tuberculosis during that time frame).

Another infectious illness that emerged in open discussion in the reports during the 1880’s was syphilis. Though listed as a treated illness in preceding years’ reports, syphilis did not appear in the narratives of any prison physicians until this time. Doctor Montgomery in 1884 asserted that ‘at least 60% of the prisoners have had syphilis and have commonly neglected to continue proper treatment sufficiently long to be cured.’⁵³ Syphilis was not connected with immorality in the reports, though the reason for this remains unclear. Syphilis was long thought of as a disease of a less than ideal lifestyle, but perhaps physicians of the time simply took it for granted that this was true and did not bother to express it in their reports.

Chronic Illness

Terminology used by the physicians more often described symptoms rather than naming actual diseases. This was probably because the practice of medicine during this time was based on more on anecdotes and case reports.⁵⁴ American medicine had not yet developed into the evidence based practice of today. For that reason, it is difficult to pinpoint all the possible chronic illnesses which affected the Ohio Penitentiary's inmate population. Certainly, infectious illnesses such as tuberculosis and syphilis were chronic diseases for which inmates were treated. Debility, epilepsy, rheumatism and dropsy were also common among the inmates. A myriad of other health concerns could have been chronic as well: bronchitis, colds, fever, lung disease and heart disease, among others. Some reports list the numbers of teeth extracted; dental caries and abscesses are chronic afflictions and likely affected inmate dental health.

Insanity

Another common thread that ran through the reports was concern with those inmates deemed insane. Inmates who were insane, especially the violently insane, were a significant issue. The dearth of facilities and treatment for these individuals are mentioned in many of the reports. No physicians' reports discussed how the diagnosis of insanity was accomplished. Aside from transfer to asylums outside of the penitentiary, no treatments for insanity were discussed. At least two physicians mention inmates who were 'cured' of their insanity and released, either back into the larger prison population or out into society at the expiration of their sentence. Some physicians were not sympathetic to mental health issues. One physician warned that if mentally ill patients were treated kindly, inmates may begin to feign insanity.

His proposed solution to this problem was that time in the Ohio Penitentiary accompanied by prison discipline would determine the veracity of the illness.⁵⁵ Another physician speculated that in some instances the men were committing crimes because of their mental illnesses.⁵⁶ Many doctors believed that mental illnesses, such as depression, could open the doors to physical illnesses because of weak constitutions, tying mental health in with physical health and lifestyle choices.⁵⁷

The lack of proper facilities to house or treat insane inmates was noted over and over again by the physicians. Requests for a place to hold and treat insane inmates are peppered through the reports, beginning in the 1860s. By 1864 a new building was constructed as an asylum. Only 14 years later, the doctor noted that treatment for the insane inmates was inadequate once again.⁵⁸ Based on some of the accounts, some of the suicides and homicides within the penitentiary walls happened because of mental health issues.

Medicine

Prison physicians rarely included information about specific medications used to treat inmates. However, a list of medications in the hospital dispensary was included by three physicians for the years 1863, 1865, 1866 and 1900. Some of the items in the lists included equipment, such as amputation tools, tooth extractors and a galvanic machine (an electro-therapeutic device). The lists also included several reference books: a medical dictionary, a medical dispensary⁵⁹ and Watson's lectures on physic.⁶⁰ The reports do not mention consulting the reference texts; however, existence of these reference materials through the years might point to a uniformity of treatment, at least until the mid-1860s.

Much of the inventory for the prison hospital did not include substances thought of as medications in the 21st Century, but did include substances very traditionally utilized in early American medicine. The lists included many different preparations of substances that would be defined as homeopathic today such as various tinctures, extracts and oils. The inventories listed materials primarily botanical in nature, such as herbs (e.g. arrowroot, goldenseal and sage); seeds (black mustard seed, caraway seed and fennel seed); roots (black snake root, valerian root and blackberry root) and flowers or seed heads (e.g. poppy heads). Chloroform and ether were also listed. Substances now thought to be poisons were commonly utilized in medical treatments of the 19th century. Listed in the inventories, mercury, arsenic, ergot and turpentine were all common materials and reflected the most current medical beliefs. Although no direct evidence exists as to their usage in the penitentiary hospital, the presence of the dispensary suggests that treatments would have been consistent with the medical knowledge of the times.

Medical treatments

From the very first reports, it can be clearly seen that prison physicians dealt with a variety of medical situations ranging from acute to chronic, infectious to non-infectious. Infectious illnesses such as cholera represented a great unknown to early 19th century physicians and as such, their concerns revolved around facing potential epidemics. However, since a large portion of the penitentiary was devoted to manufacturing, work related emergencies were an ongoing source of medical issues. Managing fractures, wounds and performing amputations and other surgeries were a normal part of prison medical care. The 1852 report lists an operation for “tapping” for dropsy (the common term at the time for

unspecified edema), an operation in which a trocar was inserted into the patient for the removal of fluid. There was no indication anyone other than the prison doctors were performing the operations, though this may not have been the case. Therefore, unlike many of their counterparts, penitentiary physicians may have had to be surgeons as well as general medical practitioners.

In the late 1880s, a trend for a new type of medical practice called orificial surgery came into fashion. The basic premise of this practice was that most ailments could be cured by operating on some orifice of the body (nostrils, ears, anus, etc). Orificial surgery was specified to treat everything from constipation, dysmenorrhea, eczema, insanity, insomnia, tuberculosis and vomiting.⁶¹ The annual report of 1889 listed 67 'successful' surgeries performed under this rubric. However, no indication was given in the report of the numbers of individuals this practiced harmed. Perhaps coincidentally, that was the last year in which he was appointed as prison physician. Certainly his replacement was likely responsible for the better health of the inmates, as orificial surgery often caused more medical problems than it solved. Unfortunately, other than these brief glimpses into prison medical treatment, the reports offered little 'best practices' to directly enlighten the modern historian as to medical care within the Ohio Penitentiary walls in the mid to late 19th Century.

Death

The very first official report of the penitentiary physician, issued in 1835, was a narrative describing illness during the year and describing the 6 deaths which also occurred. This detail with respect to the inmate deaths continues throughout the physician's reports, though in some reports deaths are summarized in tabular form. Several death descriptions contained

detailed descriptions of internal organs, alluding to the possibility of autopsies. Such examinations were not regularly described in the reports and only briefly mentioned. The ultimate reasons for the post-mortem examinations were never stated. No stated penitentiary regulations demanded autopsies and no state or local laws existed at the time regarding in-custody deaths. In 1877, Dr. Halderman commented that anatomical specimens were being taken from deceased inmates to start a pathological museum. His belief was that this was a way for the deceased inmates to pay their debt to society.

Legal executions began inside the penitentiary walls in 1885. One of the duties of the physician was to attend all executions, probably to pronounce the person dead and to record time of death. Often included in the yearly reports were accounts of the executions that took place during the year. J.W. Clemner, physician from 1886 to 1889, devoted a large portion of his 1887 report to legal executions. His discussion of execution as a scientific undertaking focused on the merits of death by electrocution as opposed to hanging.⁶²

Infectious illness was consistently the greatest cause of mortality within the penitentiary. Tuberculosis and typhoid fever were nearly endemic in the inmate population, with tuberculosis always the most common cause of death. Tuberculosis did not engender the same fears that cholera, typhoid fever and smallpox did, possibly because the symptoms of tuberculosis were not as dramatic or immediate. Popular romantic notions of the tubercular patient may have led physicians to largely ignore tuberculosis as a factor in inmate death until the 1900s.⁶³

Discussion

The physicians' words and phrases illustrate that while each man was an individual, every physician operated within the American medical and cultural lexicon of the times. This lexicon, though spanning seven decades, did not change substantially and offers modern historians a look into health conditions in a 19th century institution. The early 19th century in the United States encompassed a drive by American medical practitioners to move the science of medicine ahead. Many believed the way to accomplish this goal was through the collection and analysis of health statistics.⁶⁴ During the early 1800s, English actuary Edwin Chadwick began to advocate the usage of statistical methods to account for differences in mortality rates across different groups.⁶⁵ The idea of collecting health and mortality statistics as a way to improve medical care spread to the United States, hitting its high point during the 1860s.⁶⁶ The physician reports themselves, with their combined narrative and statistical tables, demonstrate that the Ohio Penitentiary physicians were attempting to follow this trend by collecting and presenting the statistics of their penitentiary practice. Other, more fiscally motivated reasons may have also existed for the publication of the statistics: the Ohio House and Senate controlled the budget, and justification for all expenses was certainly necessary. However, aside from the structure of the reports, the themes that run through the narratives also demonstrate that the physicians were expressing modern medical trends in their practice.

Viewpoints of inmate health were closely tied to cultural and medical ideals of the time. Health was often seen as a product of an individual's lifestyle choices. Hygiene and temperance movements of this century indicate the popular drive to construct a healthy citizenry by aiding individuals to make the correct choices in life.⁶⁷ Many believed that illness was a direct result of poor lifestyle; for example, cholera was often linked to intemperance⁶⁸. Infectious and

chronic illnesses were seen as the result of a family or individual set of circumstances that resulted in a person contracting a disease. Ultimately, even Chadwick's work linked morality and mortality, and suggested that with a morally degenerative life came a higher mortality.⁶⁹ Certainly throughout the reports there was a constant dialogue of poor inmate health as a direct result of their poor lifestyle. Clearly many penitentiary physicians believed that the immoral nature of their patients detrimentally affected their health and ultimately affected their mortality and morbidity.

Also inherent in Chadwick's work was a focus on hygiene as a way to physical health. Language surrounding penitentiary sanitation threads its way through the physicians' reports. Constant calls for better sewers, more sanitary conditions and a larger bathhouse all reflect the views that cleanliness prevented disease, reduced death, and ensured good health. Dr. Lathrop warned the prison officials in 1848 that unless sanitary measures were taken, the prison would be vulnerable to attack from cholera. Many physicians closed their reports with a statement attributing the good health of the inmates in part to the sanitary nature of the penitentiary. Ultimately the drive for hygiene translated into preventative medicine as opposed to curative medicine for many practicing physicians in the United States.⁷⁰ However, this ideal was not translated into the penitentiary in the same way as it was seen in the non-incarcerated United States culture. Since it was believed most inmates entered into the penitentiary already in a health challenged state, the physicians could work toward preventing further illness but primarily had to treat the ailments the inmates brought with them into confinement or perhaps contracted while imprisoned. This necessitated a more curative attitude as opposed to the preventative one they may have had in their practices outside the penitentiary walls.

Additional to this focus on institutional hygiene was a viewpoint of aggregate health, the “health of the institution” so often mentioned in the records. Inmate health was rarely discussed on an individual level; and it can be assumed it was rarely conceived of in that way by prison officials. On a day-to-day basis, a physician in charge of the health of hundreds of men would perhaps not be able to view or report on his responsibility in any other way. Certainly the annual reports do not allow for any individual discussion of health (the 1900 report is an exception to this).

The concept of prisoner health in the aggregate and as a result of a morally degenerative life absolved the prison physicians and officials of any ultimate responsibility for the results of treatment or care. Though some exceptions can be found to this, on the whole this was the most common viewpoint held by prison physicians and wardens. Supporting this idea was the common practice of obtaining pardons for gravely ill inmates so they could go home. Though on the surface done for the beneficent reason of allowing ill inmates to go home to get better, (or in some cases, die), there was perhaps another reason behind the practice. Pardoning ill inmates resulted in the inmate not being in official custody should he or she die. Thus, such inmates did not need to be accounted for in any way in the official records as they were pardoned prior to death and not the responsibility of the state. The physician in 1887 stated “One reason for the number of deaths occurring within the prison may be found in the fact that, contrary to custom, the Governor has refused to pardon men who were about to die within the prison, unless they were likely to recover by reason of attaining their freedom.”

No evidence exists in the official reports to the Governor, House or Senate to show there was some penalty to the officials or institution for what might be considered higher than

expected prison deaths. Prison officials held sometimes contradictory views: inmates were often inevitably in poor health due to their lifestyles; yet it was the duty of the penitentiary to alleviate what suffering and give what curative assistance they could to their charges. The reports did not construct inmate deaths as a failure of either of the second precept or as a failure of the physicians themselves. It was the duty of the physician to minimize deaths where possible; however the unstated implication in the reports was that a certain number of deaths were unavoidable. Some state governmental oversight must have been in force necessitating explanation of high numbers of inmate deaths; otherwise, prison officials would not have been so concerned, given their views on inmate health.

From inmate deaths to treating the incarcerated ill, Ohio Penitentiary physicians were responsible to the State for the health of a large number of patients. Their attempts to manage this high patient load alongside their private practices must have been a challenge. Still, as evidenced by their annual reports, the physicians tried to practice the best way they knew. Each is a product of a time in American medical history where methods were changing, new practices coming into vogue and old falling out of favor. Their words illustrate close ties with the statistical thinking of the time and their concern with sanitary conditions, insanity and methods such as orificial surgery reflect developments in American medical thinking in the late 19th Century. While prison medical care may not have been ideal, clearly the physicians were involved in the evolving medical ideas of the time.

¹ From 1846 to 1848, H. Lathrop only included summaries of the information. 1849 was the year of the cholera epidemic; a listing of illnesses treated probably seemed inconsequential since cholera took such a heavy toll on the institution. Ohio, *Executive Documents, Annual Report of the Directors and Warden of the Ohio Penitentiary, 1846-1849*. (Columbus, Ohio: State Printers). Hereinafter there are cited as AR; the year and page numbers follow where appropriate.

² The fiscal year sometimes ran November to October and sometimes November to December. AR: 1833-1907.

³ Physicians sometimes only reported 3 or 6 month intervals rather than the entire year. Others only included yearly totals. AR: 1833-1907.

⁴ Ohio Penitentiary, Intake Register, 1833-1907. Ohio Historical Society. Microfilm rolls GR3627-2628.

⁵ Typhus is caused by *Rickettsia typhi* and *Rickettsia prowazekii* while typhoid fever is caused by *Salmonella typhi*.

⁶ Harry G. Simpson, *The Prisoners of the Ohio Penitentiary*. (Columbus: Hann & Adair, Printers, 1883), 10.

⁷ Dona Reaser, *Profit and penitence: an administrative history of the Ohio Penitentiary from 1815 to 1885*. Dissertation. (Columbus, Ohio: Ohio State University, 1998), 69.

⁸ *Ibid*, 63.

⁹ Simpson, *Prisoners*, 12.

¹⁰ A dispensary was the out-patient treatment area where medications were prescribed.

Thomas Stedman, *The American Heritage Stedman's medical dictionary*, 2nd edition. (Boston: Houghton Mifflin Co., 2004).

¹¹ Mentally ill convicts are identified as 'insane' in the Penitentiary records; no differentiation was made as to type or severity of mental illness. For simplicity's sake, this paper will follow the same convention. AR: 1833-1907.

¹² AR: 1893, 6.

¹³ An inmate undergoing the hummingbird would be blindfolded and placed in a box containing 18 inches of water. A nearby steam pipe would be aimed at the inmate and turned on. A battery would be placed in the water and the inmate shocked. Ducking involved the inmate being submerged in water. Simpson, *Prisoners*, 24.

¹⁴ Physician names and dates of appointment were obtained from George Cole, *A History of the Ohio Penitentiary from 1850 to 1900*. Master's Thesis. (Columbus, Ohio: The Ohio State University, 1941), Appendices, and cross checked with the annual reports to the Governor.

¹⁵ John Phillips Resch, "Ohio Adult Penal System 1850-1900: A Study in the Failure of Institutional Reform. *Ohio History*, 1972, 81, 236-262.

¹⁶ Norman Gay was employed a total of 8 years as penitentiary physician, from 1867 to 1872 and again from 1882 through 1883. AR: 1867-1872, 1882-1883.

¹⁷ AR: 1833-1907.

¹⁸ The records of the individual physicians and the hospital registry have not been located as of this writing.

¹⁹ The penitentiary physicians at this time were always male; the only female official in the prison was the matron. Penitentiary nurses were also commonly male. AR: 1833-1907.

²⁰ Marvin E. Fornshell, *The Historical and Illustrated Ohio Penitentiary*. (Columbus: No publisher listed, 1911), 36.

²¹ AR: 1881, 88.

²² AR: 1887, 1061-1064.

²³ AR: 1838, 5. Although the quotes originate from the 1838 Board of Directors report, the sentiments are echoed throughout many reports.

²⁴ Ibid.

²⁵ AR: 1876.

²⁶ Ibid.

²⁷ Dr. Halderman's belief was that that the prison mortality rate was in part due to a free use of the pardoning power by the governor which would prevent deaths from being recorded as occurring within the penitentiary walls. AR: 1877, 960.

²⁸ AR: 1884, 255.

²⁹ AR: 1849, 249.

³⁰ AR: 1881, 1841, 1839.

³¹ AR: 1857, 229.

³² AR: 1865.

³³ An analysis of foodstuffs and expenditures on prisoner diet is in progress.

³⁴ AR: 1887.

³⁵ AR: 1874, 14.

³⁶ AR: 1859, 376.

³⁷ AR: 1861, 68.

³⁸ This inconsistency was discovered when comparing the physician reported deaths with the deaths from the database for the year 1857: the physician listed deaths was 9, the database listed 10, one of which was female. AR: 1857, 221, 228.

³⁹ AR: 1865, 241-242.

⁴⁰ Yearly totals were tabulated from the physician reports in an Excel spreadsheet and ompared.

⁴¹ AR: 1857, 229.

⁴² Simpson, *The Prisoners of the Ohio Penitentiary*, 27.

⁴³ AR: 1891, 94.

⁴⁴ AR: 1865.

⁴⁵ AR: 1883, 74.

⁴⁶ Infectious is utilized here to refer to illnesses caused by a biological organism. Contagious refers to those illnesses passed between humans.

⁴⁷ Vaccines were listed in the physician reports in the following years: 1863, 1864, 1866-1868, 1875, 1880-1882, 1894, 1895, and 1903. These were mostly likely all smallpox vaccinations, especially as several years denote 'vaccinia', which specifically indicates the smallpox vaccine.

AR: 1833-1907.

⁴⁸ AR: 1865, 249.

⁴⁹ AR: 1868, 101.

⁵⁰ AR: 1871, 118.

⁵¹ The Warden stated "It has been asserted (and is a fact) that 'more than half the time of convicts is passed in cells,' and it is not to be wondered at that so many cases of consumption are not only engendered but culminate within penitentiary walls when consideration is taken of the ventilation of these cells." AR: 1883, 33.

⁵² AR: 1883, 73.

⁵³ AR: 1884, 255.

⁵⁴ James Cassedy, *American Medicine and Statistical Thinking 1800-1860*. (Harvard University Press: Cambridge, 1984).

⁵⁵ AR: 1851, 203.

⁵⁶ AR: 1875.

⁵⁷ AR: 1854. 133.

⁵⁸ AR: 1878.

⁵⁹ A dispensatory was a book which presented symptoms and treatments known to work in clinical settings and primarily focused on botanical remedies.

(<http://www.eclecticherb.com/emp/historicalresearch.html>).

⁶⁰ The lectures were given in England by then famed physician Thomas Watson in the late 1830s and continually reprinted as reference texts for physicians. Since it was listed in the prison hospital inventory, the text must have been property of the institution and not among the personal possessions of the physician at the time. The text of 90 lectures included topics such as diagnosis and treatment of various ailments, causes of disease, identifying causes of death, and diseases specific to different parts of the body. Sir Thomas Watson, *Lectures on the Principles and Practice of Physic, Delivered at King's College, London*. (Philadelphia, Lea and Blanchard, published at various dates). No author or edition was given in the reports for either the medical dictionary or the dispensatory. AR: 1865, 260.

⁶¹ Ira Rathbow, "Orifical Surgery." *Arch Surg*, Sept 2001, 136. Accessed online at www.Archsurg.com on 2/6/2007.

⁶² The Ohio Penitentiary moved from hanging to electrocution as a mode of execution in 1896.

AR: 1896, 10.

⁶³ Matthew Gandy, "Life Without Germs: Contested Episodes in the History of Tuberculosis." In *The Return of the White Plague: Global Poverty and the 'New' Tuberculosis*. Edited by Matthew Gandy and Alimuddin Zumla. (London: Verso), 19.

⁶⁴ Cassedy, *American Medicine*, ix. Zohreh Bayatrizi, "From Fate to Risk: The Quantification of Mortality in Early Modern Statistics," *Theory Culture and Society*, 2008, 25 (1), 121-142.

⁶⁵ Bayatrizi, *Fate to Risk*.

⁶⁶ Cassedy, *American Medicine*, ix.

⁶⁷ Ibid, 25-51, 207-229.

⁶⁸ Ibid, 47.

⁶⁹ Bayatrizi, *Fate to Risk*.

⁷⁰ Cassedy, *American Medicine*, 108.

Figure 1. Numbers of inmates in the Ohio Penitentiary by year.



Table 1. List of Physicians at the Ohio Penitentiary by year.

<u>Year</u>	<u>Physician</u>		<u>Year</u>	<u>Physician</u>
1833-1834	none		1857-1859	J.W. Hamilton
1835	M.B. Wright		1860-1861	D.R. Kinsell
1836-1837	William Awl		1862-1864	Starling Loving
1838	J.G. Jones		1865	Starling Loving / C.E. Denig
1839	J.G. Jones / D. Wolfley / P. Sisson		1866	C.E. Denig
1840	P. Sisson		1867-1872	Norman Gay
1841	P. Sisson / James Irons		1873-1877	Davis Halderman
1842-1844	William Trevitt		1878-1879	W.H. Drury
1845	William Trevitt / P. Sisson		1880-1881	C.B. Ferrell
1846-1848	H. Lathrop		1882-1883	Norman Gay
1849	H. Lathrop / William Trevitt		1884-1885	C.R. Montgomery
1850	William Trevitt / J.B. Thompson		1886-1889	J.W. Clemner
1851	J.B. Thompson		1890-1891	V.H. Gorsline
1852	J.B. Thompson / B.F. Johnson		1892-1895	W.T. Rowles
1853	B.F. Johnson		1896-1899	F.S. Wagenhals
1854	B.F. Johnson / Albert De Lezinski		1900-1903	Wells Technor
1855	John Dawson		1904-1907	John Thomas
1856	John Dawson / J.W. Hamilton			