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A Bioethical Inquiry into the Moral Treatment Movement

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Master of Arts

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An abstract of

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Abstract

A Bioethical Inquiry into the Moral Treatment Movement

By Sarah Browning Putney

This paper employs both a general historical approach and a case study of the Northern Indiana Hospital for the Insane in Logansport, Indiana, during its first two decades (1888 – 1908) to examine the "moral treatment" of patients through a bioethical lens. These twenty years comprise the tenure of moral-treatment practitioner Joseph Goodwin Rogers, M.D., the hospital's design engineer and first medical superintendent. A distinguished expert in the design of mental hospitals, which were commonly called asylums, Dr. Rogers subscribed to the concerns expressed by the French physician Phillippe Pinel, who is still popularly celebrated for freeing the patients of the Bicêtre Hospital in Paris from their chains, and is known by medical historians for publishing the first nosology of mental illness. Asylum doctors like Rogers were familiar with Pinel's ground-breaking description of the methods of moral treatment ("*traitement moral*"), which was emerging in some Parisian, English, and Scottish mental hospitals in the late eighteenth and early nineteenth centuries. This asylum-based method became the leading medical treatment for the mentally ill in Europe and America throughout the nineteenth century and into the twentieth, yet the moral treatment movement is now largely forgotten, poorly understood, and misinterpreted. The reader unfamiliar with this chapter of medical history may be surprised to learn of the significant ethical motivations that drove and shaped this therapeutic movement. Benevolence, as distinct from beneficence, is identified as the leading ethical concept in the moral treatment movement as it unfolded in the U.S. and Indiana. The case study of the Northern Indiana Hospital for the Insane examines primary records including monthly and biennial reports from Dr. Rogers to the board of trustees and the governor, letters from Rogers to families of patients, and published works by Rogers shedding light on his bioethical approach to the challenges of caring for the state's mentally ill effectively and benevolently within limited means. In the final chapter, the similarity of pragmatism (as developed by William James and John Dewey in particular) to Rogers's ethics is discussed, and questions for further study are identified.

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Acknowledgments

What began as a fascination with the partial architectural remains of the "state hospital" in Logansport, my mother's home town, where everyone seems to have some sort of kinship with the hospital as an employer or otherwise, turned out to yield a master's thesis in bioethics. I am ever grateful to Professor John Banja for supporting the unusual approach I wanted to take with this study—combining historical work with bioethics—as my thesis advisor and morale booster.

Archivists Alan January and Michael Vetman at the Indiana State Library provided invaluable assistance in locating the Longcliff records. The librarian for the Logansport State Hospital, Brian Newell, sent me many valuable documents and welcomed me to the hospital museum for a tour before the state demolished the building. I am extremely grateful for their kind attention and enthusiasm for my research.

I'd like to thank the many other special people who lent their professional and moral support along the way, as Joseph Rogers said, "by every adaptable agency." My thesis committee members, Jonathan Crane and Deborah Cruze, both enriched my education as teachers and readers. Cory LaBrecque gave us a sense of excitement and the spectre of the one-piece running suit at just the right moments near the finish line. My bioethics homeys have been crucial to this journey: Aric Edwards and Kevin Wack for getting through it first and living to tell me about it by the coffee station; Annie Lai and Cynthia Drake for numerous cathartic get-togethers at our favorite watering-holes; Scotty Jenkins for keeping the bioethics dialogue going at the day job; and April Dworetz and Merrick Furst for more concurrent writing sessions at their house than I can count, and both culinary and spiritual sustenance at their table. Leonid Germanovich has been a stalwart supporter all along; thank-you for that birthday trip to start my research. Nancy Chase engaged me in thoughtful reflection about what it all means in the artistic and personal sense. Melinda Putney Farbman gave wise and funny counsel.

Finally, I thank my daughters for their loving support during this endeavor as they followed their own academic paths to Israel and Germany. Minnie and Abby, we're off on another Putney-Weisberger adventure, and may we never stop our journeys of discovery.

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Chapter 1: Introduction

Few subjects in medicine are so intimately connected
with the history and philosophy of the human mind as insanity.
There are fewer still, where there are so many errors to rectify,
and so many prejudices to remove.
--Philippe Pinel[1]

This paper will employ both a general historical approach and a case study of the Northern Indiana Hospital for the Insane in Logansport, Indiana, during its first two decades (1888 – 1908) to examine the "moral treatment" of patients through a bioethical lens. These twenty years comprise the tenure of moral-treatment practitioner Joseph Goodwin Rogers, M.D., the hospital's design engineer and first superintendent, who dubbed the hospital "Longcliff" in view of its auspicious setting on the banks of the Wabash River. A distinguished expert in the design of mental hospitals, which were commonly called asylums, Dr. Rogers subscribed to the concerns expressed by the French physician Phillippe Pinel (quoted above). Pinel is still popularly celebrated for freeing the miserable patients of the Bicêtre Hospital in Paris from their chains, and known by medical historians for publishing the first nosology of mental illness. Asylum doctors like Rogers were familiar with Pinel's ground-breaking description of the methods of moral treatment ("*traitement moral*")[2], which was emerging in some Parisian, English, and Scottish mental hospitals in the late eighteenth and early nineteenth centuries. This asylum-based method became the leading medical treatment for the mentally ill in Europe and America throughout the nineteenth century and into the twentieth, yet the moral treatment movement is now largely

[1] Philippe Pinel, *A Treatise on Insanity*, trans. D. D. Davis (Sheffield: 1806), facsimile ed. (Birmingham: Gryphon Editions, Ltd., 1982), 3.
[2] Pinel, *A Treatise on Insanity*, 48-49.

forgotten, poorly understood, and misinterpreted. The reader unfamiliar with this chapter of medical history may be surprised to learn of the significant ethical motivations that drove and shaped this therapeutic movement.

"Moral" Treatment

The first meaning expressed by Pinel's use of the word "moral" in his *Treatise on Insanity* was not, as we may assume today, "ethical." His contemporaries understood it to mean "affective," having to do with human emotions, impulses, and self-control or lack thereof. This meaning stood in marked contrast to the word "medical" as it was understood at the time to mean "using physical remedies" like bleeding and purging. In contrast to the centuries-long precedent of administering such interventions, moral treatment promoted the use of therapeutic human interactions calculated to act on the patient's psyche and emotions to help restore sanity, a sense of well-being, and self-control. Since moral treatment was delivered by people acting kindly, the other important connotation of "moral" in its historical context evolved to describe the character virtues of the care providers. The physician practitioners in charge of the asylums were required to demonstrate benevolence, kindness, and patience toward patients and ensure that all other staff followed suit. The term "moral treatment" is employed throughout this study in its distinctive historical sense.

It is important to note that when the moral treatment movement grew in the eighteenth century and spread in the nineteenth, European and American medical ethics had not yet developed to identify the now-popular principles of autonomy, non-maleficence, and beneficence. The Code of Medical Ethics was adopted and promulgated by the American Medical Association only in 1847,[3] and it expressly attributes religion as well as morality as

[3] American Medical Association website, http://www.ama-assn.org/resources/doc/ethics/1847code.pdf, accessed November 10, 2013.

its origins. The secularized system of thought that we now call principlism emerged in the twentieth century. It would not therefore be historically accurate or particularly rewarding to apply a modern principlist bioethical analysis to this study. If ethical principles are to be extracted from the historical record, however, they would have to describe the deeply institutional nature of the movement. By this I mean that the movement was inextricable from the development and management of asylums operating on culturally distinctive organizational and architectural principles. Idealized relationships among patients, doctors, government, overseers, and the public must also be captured in such principles, for these too drove the "moral" vision of the movement in both historical and modern senses. It was in these ethically imbued settings that moral treatment was lived. From this historically sensitive angle, if the principlist demand were to be satisfied in this study, it might lead us to appreciate *benevolence* (both civic and medical, both of which were expressed institutionally), *concern for public safety* (the public being embodied both as mentally ill patients and everyone else), and *accountability* to the public and by the public for its stewardship of funding and oversight of the state care for the mentally ill. We will see these concepts play out in the general history of moral treatment and the case of Longcliff Hospital.

As a reform movement, the moral treatment movement was grounded in the moral impetus to relieve suffering and to elevate the moral status of society by providing benevolent institutional care for the less fortunate members of the community. As practiced in American state lunatic asylums, moral treatment involved an unprecedented investment of public resources into the profound challenges of caring for people with mental illness who could not afford private care. It flourished before effective mind- and mood-altering pharmacotherapies were developed, and while a riot of somatic therapies was tried with few successes, moral treatment dominated the management of public care for the mentally ill in

Europe and the U.S. for over a century. Though later critics claim that the asylums built in the 19th century quickly devolved to warehouses for mere custodial care of dependent patients, the movement provided comprehensive care to large numbers of patients in public hospitals who had no better options. In spite of its deficiencies, when assessed against its historical precedent, it may rightly be considered a successful American public health movement, although it is not generally recognized as such.

By today's standards, moral treatment is holistic and immersive, taking into account all aspects of an individual's daily life, and requiring a period set apart from the rest of society. The infrastructural basis of moral treatment is the therapeutic hospital and grounds. Its driving idea is that kind and compassionate treatment by a benevolent, attentive doctor and his[4] associated staff, an orderly and well-balanced life in a family-like social organization, and a setting carefully designed and set apart from regular society, could restore mental health to persons suffering from the loss of reason, mental balance, and command of their emotions. It was a movement based on the concept of humanity as naturally possessing reason and being socially situated, thus making lucidity of mind, temperate emotions, and adjustability to social situations a natural healthy state. In its first half century it manifested extraordinary hope and confidence in the curability of mental illness.

The Therapeutic Built Environment

Throughout the first half of the nineteenth century, the majority of the American population lived in rural areas. Persons with mental illness relied on their families or friends

[4] Most alienists were men, as were most physicians in general. In the last quarter of the nineteenth century, however, we see in the records of the public asylums and leading professional organization, the Association of Medical Superintendents of Institutions for the Insane (AMSAII), that a few women became employed as assistant superintendents.

for food, shelter, the comforts of social ties, and some level of safety for as long as such people could manage to keep them. Even as every state established one or more public lunatic asylum, there were few public general hospitals (patients were treated at home), no nursing homes, no social workers, no community clinics, no outpatient visits; there was no psychotherapy, and there were no pharmacotherapies based on randomized, controlled clinical trials and subject to the safety-driven oversight of a government agency. The mentally ill who could not earn a living and lacked caregivers easily became destitute and homeless. Some were consigned by their local community law enforcers to a poorhouse, almshouse, workhouse, or jail. No specialized care for mental illness was provided in any of these settings although physicians were at times called in.

The operation of a specially-designed hospital on grounds set apart from the rest of society was an indispensable feature of moral treatment. This infrastructure provided more than the setting for therapeutic interventions by human beings; the built environment was conceived as a therapeutic agent itself. We shall see that in early stages of asylum construction, rhetoric used by advocates of moral treatment emphasized compassion for the less fortunate and the need for special treatment involving skillful interactions with patients, de-emphasizing the traditional physical remedies of bleeding, evacuants, herbs, powders, and the like, and shifting the concept of the insane person from that of a lost-soul-turned-beast requiring brutal subjugation to that of a sick person quite capable of recovery. But the method demanded the special setting free from interference. In the vast American continent, there was plenty of land and optimism for this hospital-and-grounds-based model to take root and grow without the spatial constraints of the large urban European asylums.

The asylums were semi-self-sufficient, colony-like organizations that typically operated in addition to their residence and dining halls: a farm, stables, kitchens, a dairy, a

sewing shop, a laundry, machine and carpentry shops, vegetable and flower gardens, a library, a theater, medical and dental facilities, a mortuary, a cemetery, and sometimes even a railroad branch. Almost all staff, including the medical superintendent and his family, lived on campus, in separate quarters from the patients but in a close, constantly interacting community.

For a patient admitted to an asylum, moral treatment consisted of many features aside from daily or near-daily interactions with the medical staff. Recreational activities for those who could physically manage them included dancing, long outdoor walks, chorus, band, musical concerts, theatrical shows, and reading. Hospital and landscape design had to accommodate these activities. Work was encouraged but not required or coerced in support of communal living. Assigned along gender roles of the time, patients worked in sewing, laundry, farming, landscaping, carpentry, construction, and light manufacturing. Adequate nutrition, rest, physical security, medical treatment for non-mental problems, observation and social support, and limited exposure to potentially aggravating stimuli rounded out the therapeutic inventory.

The building and grounds that made up the asylum required substantial resources for construction, expansion, and maintenance. As a state institution the asylum depended mainly on public largesse and to a much lesser though important extent on private charity. The burgeoning of the American population in the nineteenth century, the associated swell of demand for admission of mentally ill patients in the asylums, and budgetary restraints all contributed to overcrowding that directly affected the quality of moral treatment that could be delivered. In the case of Longcliff, we will examine how Dr. Rogers struggled to fulfill the healing potential of the asylum as a therapeutic built environment in spite of these serious challenges.

We will see too how moral treatment employed the classification of patients by disease categories that included their social behavioral characteristics with concern for the effects of living in close proximity on patients' mental health. It became important to Rogers to ensure that chronically ill and violent, noisy patients with poor hygienic habits were assigned to wards as far as possible from patients who were recovering or showed promise of recovering, to avoid the onset of despair among the latter which could threaten their progress. We will see how Rogers came to have strong opinions on the best design type for asylums based on this operational challenge in moral treatment and contributed to the literature toward the end of his career on this topic.

Doctors and Asylum Personnel

The growth and development of the moral treatment movement went hand-in-hand with the professionalization of psychiatrists in Europe and North America and the establishment of mental hospitals in large numbers and at an accelerated pace as the nineteenth century proceeded.[5] Treatment was practiced at the asylums by teams of three or four physicians first known as "mad doctors," "asylum doctors" and "alienists," and only later in the nineteenth century as "psychiatrists."[6] Junior doctors called assistant medical superintendents practiced at the asylums under the supervision of the medical superintendents, assisted by large staffs of attendants, nurses, and a host of tradesmen and women who made the colony-like establishments run.

The commitment of the asylum care providers to the ideals and techniques of moral treatment were sorely tested by overcrowding and underfunding. In the absence of constant supervision, the self-discipline required of asylum staff to behave patiently, wisely, and kindly

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[5] Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota, 2007), 17.
[6] Yanni, *Architecture of Madness*, 162.

could not be consistently applied, allowing for scandalous abuses. The success of asylum medicine depended on effective management of personnel even more than the maintenance of the built environment. We will see how Joseph Rogers handled staff misbehavior in a way that reinforced the primacy of compassion for the patients and the nobleness of asylum work.

Of course even when practiced properly, moral treatment did not help every patient to recover. Mounting evidence of failure over the years led to the perception of the asylums as warehouses for "incurables." We will see how Joseph Rogers refused to accept the term "incurable" as a term for use in communicating with patients and as a justification for what we now call futility judgments that might lower the quality of care. As the numbers of asylum patients with chronic illness increased, compassion in moral treatment took on a new twist: not to give up hope on chronically ill patients by calling them incurable, thereby devastating their own hopes of getting better; and not to give up on the value of "custodial" care (shelter, food, clothing, non-psychiatric medical care, supervision, and social belonging) for all patients regardless of their prognosis for recovery.

In a speech he gave as President of the American Medico-Psychological Association in 1900, Joseph Rogers reflected on the inevitable need to compromise theory in practice: "So many and so incongruous are the conditions to be met, that even theoretical methods and means must conflict, and the practical sum total must involve more or less compromise. This is true more particularly of public provision for the insane."[7] There is probably no more poignant example of compromise in moral treatment than the use of physical restraints on patients within ethically sound parameters.

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[7] Joseph G. Rogers, "A Century of Hospital Building for the Insane," Presidential Address to the American Medico-Psychological Association at the 56th Annual Meeting, Richmond, Virginia, Vol. LVII *American Journal of Insanity,* no. 1 (1900): 2.

It is in the operationalizing of the moral treatment theory that compromise occurred, but it was not necessarily an inevitable response or one that issued automatically. The compromises took place in the context of morally motivated struggles. Examining each of these dilemmas as experienced at Longcliff Hospital, we will see how Dr. Rogers strove creatively to resolve them to realize the ethical and medical potential of the movement in spite of relentless challenges.[8]

Since the moral treatment movement is not well known to the contemporary public, nor even to the psychiatric or bioethics professions today, a history of the movement's English and French origins, growth in the United States, and development in Indiana will be provided in the next three chapters before we turn to a history of how Dr. Rogers and the state of Indiana created Longcliff Hospital. We will especially examine the ethical beliefs, assumptions, and principles that shaped that development. Then we will look at the challenges of managing the ethical use of physical restraints at Longcliff, and Dr. Rogers's struggles to implement moral treatment throughout the built environment and by managing the "moral" behavior of hospital staff. We will turn to his dilemma of how to apply moral treatment to the care of so-called "incurable" and "chronic" patients in the face of pressures to neglect or give up on them. Finally we will consider how this historical study may enrich our contemporary understanding of "moral" treatment of the mentally ill.

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[8] This paper draws on the rich archives of Longcliff Hospital and the records pertaining to Dr. Rogers kept by the Indiana State Library in Indianapolis and the Logansport State Hospital in Logansport; and other records from Dr. Rogers' own papers kept at the Lilly Medical Library of Indiana University in Bloomington.

Chapter 2: Origins in England and France

Precedent to Moral Treatment: Medieval and Classical Medicine

In order to fully appreciate the revolutionary nature of moral treatment, let us review the context of medical theory and practice from which it emerged. The medical frames of reference bore little resemblance to those of today.[9] A clear distinction between mental and physical disease was not part of the conceptual framework and there was no specific theory of or focus on the relationship between mind and body.[10] Until the mid to late eighteenth century, insanity was not widely contemplated as a disease requiring medical treatment. In medieval times, madness was popularly understood as a condition of possession by evil spirits who jettisoned one's humanity and took over one's self-control, rendering a person bestial and brutish, deserving of crude control and harsh treatment.[11] On such a basis could chains and corporal punishment be justified.

During the seventeenth and eighteenth centuries, European medicine still worked with the classical Greek humoral model of disease. In this tradition, disease was a general disorder resulting from an imbalance in the four humors (basic juices or liquids) that occupied the human body: phlegm, blood, black bile (melancholy), and yellow bile (choler).[12] To counteract the overproduction of a humor, a process to remove the excess was indicated, such as purging or bleeding.[13] It was also thought that the pace of circulation of the blood could be too sluggish or too fast, and that the textural, temperature, and color qualities of the humors contributed to illness.[14] Humoral and kinetic excess or deficiency was associated

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[9] Gerald N. Grob, *The Mad Among Us* (Cambridge: Harvard University Press, 1994), 8.
[10] Ibid., 11.
[11] Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), 93.
[12] Ibid., 37-38.
[13] Grob, *The Mad Among Us*, 9.
[14] Porter, *Madness: A Brief History*, 36-43.

with illness, and humoral balance was associated with good health. According to Hippocrates (c. 460-357 BCE), for example, madness resulted from humidity of the brain, although like others of the ancient Greek and Roman philosophers he believed that some part of the mind was located in the left cardiac ventricle.[15] "As long as the brain is at rest the man enjoys his reason; depravement of the brain arises from phlegm and bile; those made from phlegm are quiet, depressed and oblivious; those from bile excited, noisy and mischievous."[16] Galen (c. 129-199 CE) agreed that the brain was the primary organ involved in mental diseases. Both Hippocrates and Galen advocated keeping the supernatural out of disease theories and promoted clinical observation to understand disease, while reserving due respect for the unknown and the powers of deities to affect the natural world.[17] Treatments advised by Galen involved balancing the humors as well as regimens for sleep, diet, and medicinal applications such as tonics, lotions, and salves.[18] Interestingly, two millennia of clinical observation have produced some agreement: the two major conceptual categories of illness—melancholia and mania—endured into the nineteenth century and the moral treatment movement.

Another medical theory originating in ancient Greek philosophy that endured into the nineteenth century and shaped the experience for patients in moral treatment is the theory of the miasma. This idea that air and its currents spread disease to humans eventually, in nineteenth-century America, supported a near obsession with indoor ventilation in asylum design and plentiful time outdoors for patients. This theory prevailed in the first half of the nineteenth century before germ theory emerged to overtake it as an

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[15] James Richard Whitwell, *Historical Notes on Psychiatry* (London: H. K. Lewis & Co., 1936), 62-63, 153.
[16] Ibid., 63.
[17] Ibid., 61-62, 83-86.
[18] Ibid., 87-89.

explanation of disease etiology.[19] In Chapter Three we will encounter this theory in more detail in its application to moral treatment.

Before the moral treatment movement emerged to guide new asylum construction, English and French asylums were either converted private houses run by laymen or doctors as businesses, or older facilities converted from other uses; the first Bethlem asylum was a priory, and the Salpêtrière was originally a salt peter factory.[20] Doctors comprised a wide range of men, including amulet peddlers and barber-surgeons, men with little formal training, and gentlemen educated in philosophy and the natural sciences. Some madhouse directors were not doctors, since the places were organized with an emphasis on confining and minimally sustaining the mentally ill, not curing them of a medical condition.

Of the early public institutions, the Bethlem Hospital in London was and remains the most notorious; eventually it served as the antithesis of all the American asylum movement sought to represent. Known colloquially as "Bedlam,"[21,22] this institution's nickname became synonymous with human chaos, a fair assessment of the most agitated and violent behaviors of its most severely afflicted inmates, and the inability or unwillingness of their keepers to treat them with compassion. Bedlam provided merely minimal support; heating was severely limited, windows generally were barred and unglazed, clothing and bedding scant (it was commonly believed that insane persons were immune to the discomfort of extreme heat and cold).[23] Activities to exercise the mind and body, the quality

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[19] In 1854, John Snow figured out that the cholera epidemic in London was caused by a sewage-contaminated water supply. Steven Johnson, *The Ghost Map* (London: Penguin, 2006).
[20] Yanni, *The Architecture of Madness*, 17, 26-27.
[21] Porter, *Madness: A Brief History,* 107, 166.
[22] *Oxford English Dictionary,* Second Ed., Vol. II (Oxford: Clarendon Press, 1989), 51. Originally established as the Hospital of St. Mary of Bethlehem in 1247 as a priory; by 1330 it was mentioned as a hospital and by 1402 as a hospital for the care of lunatics. Eventually it was transferred to London's control and by 1547 established as a royal foundation for the reception of lunatics.
[23] John Haslam, *Observations on Insanity: with Practical Remarks on the Disease, and an Account of the Morbid Appearances on Dissection* (London: F. and C. Rivington, 1798), 35-36.

and quantity of food, and facilities for hygiene were all inadequate and unhealthful. Chains and other mechanical contraptions were commonly used to restrain inmates for the convenience of the keepers as well as to protect patients from self-harm. Economic motives on the part of keepers easily justified providing less instead of more, for both private and public madhouse patients.

Enlightenment Concepts

The shift from asylums as restraining, often brutalizing, places staffed by virtual jailers to settings built for treatment staffed by specially trained practitioners of kindness and psychological techniques would not have happened without the radical influence of the Enlightenment. Especially significant was the idea that the human mind develops from sensory perception, and therefore that experience, mental reflection and association all have their genesis in the sensory processes. With this concept of mental order as a foundation, it could be reasoned that human mental disorders could be cured through rationally designed behavioral and environmental interventions that resensitized the mind; and such a theory justified less reliance on (even the elimination of) somatic remedies for treating the symptoms of madness. It also eliminated the conceptual justification of brutality toward the insane and neglect of their physical, emotional, and social needs; far from being forever bereft of humanity, insane persons were susceptible to the curative effects of humane treatment through their affective faculties.

Although we celebrate the Enlightenment for the development of the scientific method based on careful observation, reflection, and analysis, its philosophers also carefully

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http://find.galegroup.com.proxy.library.emory.edu/ecco/infomark.do?&source=gale&prodId=ECCO&userGroupName=emory&tabID=T001&docId=CB127167651&type=multipage&contentSet=ECCOArticles&version=1.0&docLevel=FASCIMILE.

reasoned through and affirmed the existence and supremacy of God.[24] In the history of the moral treatment movement we should not lose sight of the religious underpinnings of the idea of benevolence—wishing well and doing good for the sake of others as a reflection and extension of divine lovingkindness toward human beings.[25] The concept of one God as the creator and legislator of the natural world[26] and Christian concepts of brotherly love played meaningful if perhaps understated roles in the moral treatment movement. Within these philosophical and spiritual lines of thinking, it was possible for ideas of societal obligation to the insane to grow from the limited practical need to remove them from society and subjugate them while providing just enough means to keep them miserably alive, to establishing hospitals organized to provide the support, comfort, and stimuli needed for healing to occur.

We will look now at the two predominant courses in which moral treatment developed in Western Europe: through the Enlightenment-influenced physicians represented by John Haslam at the Bethlem Hospital in London and Philippe Pinel in Paris, and the religiously inspired work of Quaker William Tuke and the Yorkshire Society of Friends.

John Haslam's Observations on Insanity

John Haslam (1764 - 1844) served as the apothecary at the Bethlem Hospital from 1787 to 1816[27] after studying medicine in London hospitals and in medical classes at Edinburgh. His service at Bethlem allowed him the means to study insanity, somatic and

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[24] Descartes, for example, reasons through the existence and nature of God in *Meditation III* and *Principles of Philosophy, Part I*. *The Philosophical Works of Descartes,* rendered into English by Elizabeth S. Haldane and G.R.T. Ross. (Cambridge: Dover facsimile ed., 1955, of Cambridge University Press ed., 1931).
[25] *Oxford English Dictionary*, 112.
[26] John Locke, *An Essay Concerning Human Understanding,* abridged and ed. Kenneth P. Winkler (Indianapolis: Hackett, 1996, originally published 1689), 18.
[27] George Clement Boase, *Dictionary of National Biography,* 1885-1990, Vol. 25. http://en.wikisource.org/wiki/Haslam,_John_(DNB00), accessed December 28, 2013.

moral treatments, and to conduct autopsies. His *Observations on Insanity*, published in 1798, was an influential contribution to the development of scientific approaches to the study of insanity during his time as well as an historical window on the evolving practices at the Bethlem Hospital at the end of the eighteenth century. It would be fair to say that the Bethlem Hospital Haslam describes is in a muddle of competing theories, empirical observations, and practices both older and newer. On the one hand, it still clings to the idea that organic causes should be detectible even though autopsies yield little supporting evidence, and on the other, it seeks some theoretical system by which to understand the variety and intransigency of mental diseases encountered in practice. Haslam's frame of reference for his basic concept of the human mind is John Locke's *An Essay Concerning Human Understanding*. This theory is so important that a summary is in order before we proceed.

Locke argued against the Cartesian belief that human beings are born with innate knowledge or principles, either moral (ethical) or practical;[28, 29] likewise he rejected the "received doctrine" that one's character is impressed at birth.[30] The *Essay* propounds the reasoned judgment that all human ideas come from sensory perception or mental reflection thereon.[31] Liberty or freedom is the power to think or not, to move or not; and essential to liberty are thought, volition, and will.[32] Will is a power of the mind, motivated by uneasiness, which must be removed to restore happiness. Desirable as liberty may be, it is improved by the government of one's passions.[33] "[H]e that has a power to act, or not to act according as

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[28] Locke, *Essay*, 8-17.
[29] Albert G. A. Balz, *Descartes and the Modern Mind* (New Haven: Yale University Press, 1952) 164 N18, 175 N18.
[30] Locke, *Essay*, 33.
[31] Ibid., 33-34.
[32] Ibid., 95-96.
[33] Ibid., 109.

such determination [of will] directs, is a *free agent*…"[34] Reason is the faculty of man's "whereby man is supposed to be distinguished from beasts, and wherein it is evident he much surpasses them."[35] Reason is needed to expand man's knowledge and to assist with all his other intellectual faculties. Locke counts four degrees of reason: (i) discovering truths; (ii) the regular and methodical disposition of truths; (iii) perceiving their connection; and (iv) making a right conclusion.[36] The *Essay* sets forth a system contemplating all of the mental (including emotional) faculties of the mind that are involved in individual mental health.

Given this concept of reason, Locke argues that the opposite of it is madness.[37] "If to break loose from the conduct of reason, and to want that restraint of examination and judgment, which keeps us from choosing or doing the worse, be *liberty*, true liberty, madmen and fools are the only freemen: but yet, I think, nobody would choose to be mad for the sake of such *liberty*, but he that is mad already." (Emphasis original.) A sympathetic attitude toward madness is detectible here, suggested as a reflection of divine mercy: "But if any extreme disturbance…possess our whole mind…we are not masters enough of our own minds…God, who knows our frailty, pities our weakness, and requires of us no more than we are able to do…"[38] Everyone is capable of madness, says Locke, and it is subject to both prevention and cure.[39] Through the unfortunate association of ideas, people can develop the sort of incorrect ideas and beliefs associated with madness; just as education of the mind can shape it through sensory, environmental, affective means, so can cures of mental disorders take place over time with similar means rather than by the pressing of reason on a disordered

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[34] Ibid., 107.
[35] Ibid., 313
[36] Ibid., 314.
[37] Ibid., 314, 172-173.
[38] Ibid., 109.
[39] Ibid, 172-173.

mind.[40] The importance of education of the young is likewise obvious from this line of thinking.[41]

What the experienced practitioners like John Haslam brought to this discourse on the mind were descriptive accounts from hospital practice that would augment the existing data on insanity and promote new scientific study and thought. Haslam's definition of insanity owes as much to his own observations as to Locke:[42] "Insanity may…be defined to be an incorrect association of familiar ideas, which is independent of the prejudices of education, and is always accompanied with implicit belief, and generally with either violent or depressing passions." At times, however, Haslam's observations of patients challenged the unity of Locke's system. In reality, it seemed, insane people showed a remarkable variety in the workings of their minds; combinations of deficiencies and abilities usually fit nicely into the view that one defect could bring down the entire mind, but not always. Thus Haslam wrote: "The sound mind seems to consist in a harmonized association of its different powers and is so constituted, that a defect, in any one, produces irregularity, and, most commonly, derangement of the whole." *Most commonly* implies that exceptions to the general rule have been observed by the author. It was also evident to Haslam that both sane and insane persons could display the same kinds of mental behaviors: "It has often been observed that madmen, will frequently reason correctly from false premises, and the observation is certainly true: we have indeed occasion to notice the same thing in those of the soundest minds."[43]

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[40] Ibid., 174-175.
[41] Ibid., 172.
[42] Haslam, *Observations on Insanity,* 10.
[43] Ibid., 8.

John Haslam expressly acknowledged his debt to Locke's fundamental work on the sensory origins of the mind while downplaying the tensions between his own observations and the philosophical foundations of his understanding. *Observations* begins with a reference to Locke by way of Haslam stating his disagreement with a colleague, Dr. Ferriar, who claimed that insanity results from false perception and a resulting confusion of ideas:

> By perception, I understand, with Mr. Locke, the apprehension of sensation; and after a very diligent enquiry of patients who have recovered from the disease, and from an attentive observation of these laboring under it, I have not frequently found, that insane people perceive falsely, the objects which have been presented to them. It is true, that they all have false ideas, but this by no means infers, a defect of the power by which sensations are apprehended in the mind…It is well known, that maniacs often suppose they have seen, and heard those things, which really did not exist at the time; but even this I should not explain by any disability, or error of the perception, since it is by no means the province of the perception to represent unreal existences to the mind. It must therefore be sought elsewhere probably in the senses, or in the imagination.[44]

Thus, elsewhere in the senses or the imagination, Haslam accepted the possibility of causes both physical and moral. His definition of moral causes "are meant those which are applied directly to the mind" – "grief, ardent and ungratified desires, religious terror, the disappointment of pride, sudden fright, fits of anger, prosperity humbled by misfortunes; in short, the frequent and uncurbed indulgence of any passion or emotion, and any sudden and violent affection of the mind."[45] At Bethlem he saw it all.

He admitted to no knowledge of the proximate causes of mental illness but believed that as we understood better how far disease attacking any part of the brain may affect its functions, we should understand the causation of mental illness. Haslam showed great optimism that the scientific study of the morbid states of the brain (via dissections) would

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[44] Ibid., 3-5
[45] Ibid., 100.

provide the most information toward this objective, and yet the series of dissections he reports appear to yield little evidence to support any theories.[46]

In the face of overwhelming uncertainty about causation, with such faith in empirical methods to gain knowledge and develop useful classifications over time, the prospect of cure appeared to lie far ahead though not out of reach. There remained the work of gathering the information to share with colleagues to promote the development of classifications, but the task itself of discerning order from nature also defied obvious or easy solutions. Haslam himself found it difficult to draw consistent conclusions from his own experience. For example, he advocated paying more attention to the intellectual faculties of patients than to their passions for clues to their mental condition, but saw the main difference between mania and melancholia as the emotional disposition: "In both [mania and melancholia], the association of ideas is equally incorrect, and they appear to differ only, from the different passions which accompany them." Dissection showed no difference between the manic and melancholic brains, and the most successful treatment he had observed did not differ between mania and melancholy. Clearly the state of medical knowledge of insanity was in need of much further work. In the meantime, patients must be cared for, and Haslam also shared in his *Observations* some accounts of how Bethlem Hospital cared for patients.

At the time Haslam published *Observations*, Bethlem Hospital was using a combination of traditional means and new moral techniques. In a rather severe concession to pessimism, patients were classified as curable and incurable (lists were kept), chains were used on the most agitated or violent patients in both horizontal and vertical positions, and straightjackets too, although Haslam advised that "[c]oercion should only be considered as a

[46] Ibid., 102.

protecting and salutary restraint."[47] In this respect he disagreed openly with Dr. Cullen, a colleague, who advocated corporal punishment "with a view of rendering them rational by impressing terror." Calling this "disgraceful and inhuman treatment," Haslam reasoned, "If the patient be so far deprived of understanding, as to be insensible why he is punished, such correction, setting aside its cruelty, is manifestly absurd. And if his state be such, as to be conscious of the impropriety of his conduct, there are other methods more mild and effectual."[48] By these methods of course he meant moral ones.

Haslam makes his claim for the efficacy of moral methods on the basis of his own observed experience. "[B]y gentleness of manner, and kindness of treatment, I have never failed to obtain the confidence, and conciliate the esteem of insane persons, and have succeeded by these means in procuring from them respect and obedience." Thus he describes the essential mechanism of moral treatment: by treating a patient respectfully and kindly, the patient recovers self-esteem and self-control. A mutual regard is established on the strength of which the patient can invest confidence and trust in the keeper or physician, and within this relationship (which we would today call a therapeutic one) further reworking of the patient's mind and healing of his mental and physical ills can be accomplished. For example, if a patient refuses to eat, the lack of nutrition endangers his life. If the patient trusts the keeper who brings his food and tells him he cares about his health, he may agree to take nourishment, whereas if he distrusts his keepers, he may not. If a patient becomes agitated, his respect or hatred for his keepers would make the difference between cooperating to calm down and escalating defiance that might provoke temporary confinement or restraint.

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[47] Ibid., 126.
[48] Ibid., 124-125.

Haslam reveals that moral treatment did not exclude the manipulation of a patient's feelings and social concerns; it was not all about kindness for kindness's sake. "As madmen frequently entertain very high, and even romantic notions of honour, they are rendered much more tractable by wounding their pride, than by severity of discipline."[49] He recounts favorably the keeper's ordering the confinement of a "delinquent" in the presence of other patients to display authority, so that the miscreant "becomes awed by the spectators, and more readily submits."[50] Self-control and obedience to authority were considered forms of cooperation that facilitated successful treatment and return to society.

Moral treatment methods brought a new creative potential to the use of confinement of patients. Rather than provide punishment of a patient or protection from him for others, confinement could now serve as the setting for moral treatment. On this point, Haslam made clear that confinement should be understood as removal from home. "The interruptions of his family, the loss of the accustomed obedience of his servants, and the idea of being under restraint in a place where he considers himself the master, will be constant sources of irritation to his mind...It is a well-known fact, that they are less disposed to acquire a dislike to those who are strangers, than to those with whom they have been acquainted; they become therefore less dangerous, and are more easily restrained." A patient could more easily be kept calm and susceptible to treatment away from the environment of home where the patient's identity has become painfully ill adjusted.[51]

Just as custody of a patient placed tremendous responsibility in the hands of the asylum keepers, moral means put the onus on the practitioners to maintain self-control and good judgment and be ready for immediate action in their behavior towards patients. On

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[49] Ibid., 128.
[50] Ibid., 123-124.
[51] Ibid., 133-134.

this point Haslam's opinion, again based on his experience, was so subject to collegial concurrence that Pinel quotes the following excerpt in his own *Treatise on Insanity*: [52]

> It should be the great object of the superintendant to gain the confidence of the patient, and to awaken in him respect and obedience: but it will readily be seen, that such confidence, obedience, and respect, can only be procured by superiority of talents, discipline of temper, and dignity of manners...[M]isconduct, and empty consequence, although enforced with the most tyrannical severity, may excite fear, but this will always be mingled with contempt…it is to be understood that the superintendant must first obtain an ascendency over them. When this is once effected, he will be enabled, on future occasions, to direct and regulate their conduct, according as his better judgment may suggest. He should possess firmness; and, when occasion may require, should exercise his authority in a peremptory manner. He should never threaten, but execute: and when the patient has misbehaved, should confine him immediately.[53]

This is a tall order for any human being. It would be easy for the person in charge, let alone an attendant, to fall short of these exacting standards of character and behavior under the stresses of life in the insane asylum. Human fallibility recurred throughout the moral treatment movement. Later in this study we will see how practitioners explored the potential of the built and natural environments to do as much therapeutic work as possible. It is possible that as the limitations of human agency to effectuate treatment in the hospital setting were encountered, the movement sought more effect from environmental and occupational therapies.

In Haslam's account of Bethlem, we see a time and place of transition. The one aspect of moral treatment he does not address is that of the built environment as therapeutic agent. On this point, Pinel and the Quakers had more to say.

Philippe Pinel and Philosophy of the Human Mind

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[52] Pinel, *A Treatise on Insanity*, 189-190.
[53] Haslam, *Observations on Insanity*, 122.

Philippe Pinel worked under the intellectual influence of the Ideology movement in Paris in the latter two decades of the eighteenth century. *Idéologie* was a Lockean school of thought that argued that human knowledge exists only on the basis of sensory processes, that ideas arise only from sensory experience. Led by the French epistemologist, Roman Catholic abbot, and pioneer of psychology Étienne Bonnot de Condillac (1715-1780), this radical empiricism inspired Pinel to apply the empirical method to medical theory.[54] "The time, perhaps, is at length arrived when medicine in France, now liberated from the fetters imposed on it, by the prejudices of custom, by interested ambition, by its association with religious institutions, and by the discredit in which it has been held in the public estimation, will be able to assume its proper dignity, to establish its theories on facts alone, to generalize those facts, and to maintain its level with the other departments of natural history."[55]

Pinel argued that the medical doctor should study broadly; "the knowledge of the human passions…deserves peculiar attention."[56] By "passions" he meant emotions stirred to expression in action, great enthusiasm, or energy in motion. He referred readers aspiring to "trace the numerous changes and perversions of the human understanding with success" to "cultivate an intimate acquaintance with the writings of Locke and Condillac."[57] Locke's *Essay Concerning Human Understanding* contributed the fundamental construct of the development of the human faculties, but Pinel noted even more pointedly than did Haslam that this system does not satisfactorily explain all of the many facets of disordered minds.[58] For example, a silversmith patient who believed his head had been exchanged with that of someone else had otherwise fine cognitive function. Pinel permitted the man to engage in

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[54] Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1973), 39-40.
[55] Pinel, *A Treatise on Insanity*, 45.
[56] Ibid., 46.
[57] Ibid.
[58] Ibid., 26, 83-84.

extensive mechanical activities to pursue his interest in perpetual motion, during which exercises he created many ingenious contraptions but remained delusional. Pinel noted that this case challenges the doctrine of the unity and individuality of the human mind set forth by Locke and Condillac.[59]

During the last twenty years of the eighteenth century Pinel gravitated toward the study of mental disease, sadly prompted by the suffering and death of a mentally ill friend in 1783. Following two years at the Bicêtre, in 1795 he moved positions to practice at the Salpêtrière hospital, also in Paris. As author of the major work, *Nosographie philosophique ou méthod de l'analyse appliquée a la medicine* (Philosophical nosography, or method of analysis applied to medicine), published in 1798, Pinel became famous in his time; he considered this his and France's major contribution to medical thought and practice, something the English had not accomplished. Without a nosology and treatment techniques appropriate to the category of disease and the individual patient, he argued, practitioners are hard pressed to apply moral management and to know when it would be better left untried. Although widely believed today to be an inventor of moral treatment, a reading of Pinel's *Treatise* quickly reveals that he reported the ingenious practices of others, including non-physician asylum "governors" (superintendents), whom he studied and emulated. Perhaps because he was not tied to apothecary work as was John Haslam, Pinel was freer to spend time with patients and asylum staff, and he had a broader field of observation, while being well informed of the writings of Haslam and other contemporaries on the subject of insanity.

Pinel was renowned as a great teacher (1795-1822) and systematizer of internal medicine. His other publications included *Medicophilosophical Treatise on Mental Alienation* (1801) and *Clinical Medicine* (1802), a collection largely of case histories including some

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[59] Ibid., 26.

developed from his own students as patients.[60] As with Haslam, observation was the keyword and method; from the observation of symptoms, the simple and then complex diseases could be understood and classified. Many others built upon (and improved) his work; as a beloved teacher and colleague, he wielded tremendous influence over his own and the next generations of academic practicing physicians. His influence on clinical instruction, based in the hospital, was significant.[61]

Like Haslam, Pinel's focus on clinical observation of symptoms led him to embrace multiple causal factors for mental illness including traumatic head injury, heredity, social and physical environments, extreme passions, and alcohol abuse. Clinical observation encompassed more than biological facts and symptomology, gathering in the personalities, individual narratives, and emotional aspects of patients. Perhaps noting the lack of conclusive evidence provided by Haslam, he rejected the belief in causation of insanity from organic lesions in the brain and resulting incurability[62] and insisted that the combinations of causes and symptoms are essentially endless.[63] "My experience authorizes me to affirm, that there is no necessary connection between the specific character of insanity, and the nature of its exciting cause…The violence of maniacal paroxysms appears…to be independent of the nature of the exciting cause; or to depend, at least, much more upon the constitution of the individual,--upon the different degrees of his physical and moral sensibility."[64]

The *Treatise* manifests a distinctive ability to combine factual observation with respect and compassion for patients; indeed, Pinel admits his writing "is calculated to

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[60] Erwin H. Ackerknecht, *Medicine at the Paris Hospital, 1794-1848* (Ann Arbor: University of Michigan Press by e-distribution, orig. Baltimore: Johns Hopkins University Press, 1967), 48, 51. http://hdl.handle.net/2027/heb.05736.0001.001.
[61] Ibid., 48-51.
[62] Pinel, *A Treatise on Insanity,* 3, 5, 133, 158-159.
[63] Ibid., 14-15.
[64] Ibid., 15.

interest our best and tenderest sympathies."[65] Seeing in his patients the full panoply of human experience, he advocates for their "moral" qualities in the full sense of the word encompassing emotional and ethical:

> I cannot here avoid giving my most decided suffrage in favour of the moral qualities of maniacs. I have no where met, excepting in romances, with fonder husbands, more affectionate parents, more impassioned lovers, more pure and exalted patriots, than in the lunatic asylum, during their intervals of calmness and reason. A man of sensibility may go there every day of his life, and witness scenes of indescribable tenderness associated to a most estimable virtue.[66]

Pinel, a man of sensibility, writing to a largely medical audience of readers, must have assumed that they included more than a few fellow men of sensibility who shared his objectives. Pinel's use of the phrase "*traitment moral*" meant asylum staff operating with the psychological and affective means on the same faculties in patients rather with physical means on the patient's body. In order to effect such treatment, providers had to draw on their own moral faculties; through a circuit of kindness and response in kind, the provider and patient created the mutual respect and trust necessary for comfort and healing to occur. This domain of care employed physical means such as a healthy and adequate diet, sleep, and care for concurrent disease to strengthen the patient and relieve pain or discomfort, but did not rely on physical means for success in the mental healing.

Much of the *Treatise* is devoted to accounts of cases in which the asylum staff demonstrated the character virtues also connoted by the word "moral." Pinel expounds on how the generosity and compassion of the hospital governors (non-physician superintendents) permeated the management of the asylums.[67] He relates numerous anecdotes demonstrating the wisdom and creativity of hospital governor M. Poussin and his

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[65] Ibid., 16.
[66] Ibid.
[67] Ibid., 84.

wife, the governess, in their therapeutic interactions with difficult patients. The ingenuity of these worthies and Pinel himself is at times remarkable, and yet occasionally their choice of intervention appears to favor short-term gain over predictable negative consequences. For example, Pinel organized a mock tribunal for a patient plagued by a delusion that he had been indicted on a political charge and at any moment might be taken away by government officials. (Many of Pinel's patient accounts reflect the political instability of the Revolutionary times.) The idea was to bring the patient face-to-face with the object of his fears but have the verdict turn out as acquittal or dismissal to liberate him from his self-condemning delusion. While this bit of theater rendered the desired relief to the patient temporarily, it backfired when an asylum attendant revealed the deception to him. The unfortunate patient relapsed severely and died uncured.[68]

Pinel's insistence on a humane, non-restraining approach to hospital care for the mentally ill bore the flavor of the French Revolution era during which greater individual liberty (at least for some populations) became a predominant cultural value.[69] This should not be confused with total egalitarianism, however; the hospitals were operated by men (and some women) in authority with whom patients were encouraged to cooperate. Most importantly, patients were encouraged to earn and sustain their esteem. The goal of care was to help the patient regain autonomy over his passions, restore reason to its place among the faculties, and function in society again. With so much riding on the human interventions, Pinel advised on the crucial importance of hiring good staff and constantly supervising them to avoid abuses.[70] One potential downfall of moral treatment lay in its dependence on human beings to deliver it.

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[68] Ibid., 228.
[69] Grob, *Mental Institutions In America*, 41.
[70] Pinel, *A Treatise on Insanity,* 44, 53-54, 68.

Pinel saw other limitations to moral treatment as well. Whereas Condillac applied empirical analysis to the development of "certain mental emotions" such as inquietude and desires of all kinds, in taking this line of inquiry farther in medical philosophy that had to address the emotional conditions of insanity, Pinel found no evidence that lack of (or "lesions" of) will was effectively treated by moral treatment. He concluded that moral treatment would not help a patient whose insanity was comprised only of a lesion of will. Hence he did not see how Locke's and Condillac's principles of development explained lesions of the will and the failure of moral treatment to change them. By default and experience, he prescribed antispasmodics for lesion of will and prevention by evacuants.[71]

Where human beings in the form of asylum personnel could not always deliver efficacy and contemporary science could not always guide practice, Pinel could see that the built environment and exposure to the natural world also acted on the sensory perception and affective faculties of patients. The hospitals in which he worked were not "purpose-built"[72] built according to the designs of moral practitioners, as we shall see was the case with the Quakers' York Retreat and nearly all of the asylums in the United States. But Pinel commented on the salubrious effects of light outdoor exercise and occupation with productive activities (without excessive expectations),[73] which were to become staples of moral treatment elsewhere. He also advised on the usefulness of classifying and separating patients by disease category to prevent the healthier and convalescing patients from the destructive effects of proximity to the more agitated and disturbed patients.[74] A century later, Joseph Rogers would confirm this opinion with his own from decades of experience.

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[71] Ibid., 83-84.
[72] Yanni uses this term throughout *The Architecture of Madness*.
[73] Pinel, *A Treatise on Insanity,* 195.
[74] Ibid., 174.

However mischaracterized it may have become through the reliance on secondary and more remote interpretations, in spite of not inventing but recounting the work of others, Pinel's treatise did lead the way for the clear articulation of what Charland has termed the "first modern medical theory of how a therapy guided by affective and ethical notions tied to benevolence can alleviate mental illness."[75] Equally significant from a bioethical and historical viewpoint is that this theory broke from reliance on somatic remedies: "…in diseases of the mind…it is an art…to administer medicines properly: but it is an art of much greater and more difficult acquisition to know when to suspend or altogether omit them."[76] For Pinel, the "art" of the physician could be developed by an empirical approach to illness and treatment, and the nosology he created offered the basis for differentiating treatment among patients with different disorders.

The Yorkshire Quakers

In eighteenth-century England, the Quakers (Society of Friends) led the development of moral treatment separately from the efforts of others but similarly as a benevolent response to traditional asylum conditions and in accordance with Lockean theory about the human mind being shaped by experience. Quakerism originated in England in the 1650s as a reformatory Christian movement against the Church of England, inspired by George Fox (1624-1691) to recover the immediacy of Jesus Christ as an ever-present, personal guide to his followers rather than a distant historical event requiring mediation through the Church.[77] Its central assumptions include the divine authenticity of personal revelatory experience and the practical importance of demonstrating faith in everyday life

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[75] Louis C. Charland, "Benevolent Theory: Moral Treatment at the York Retreat." Vol. 18 *History of Psychiatry* (2007), 63. Doi: 10.1177/0957154X07070320.
[76] Pinel, *A Treatise on Insanity,* 5.
[77] D. Elton Trueblood, *The People Called Quakers* (New York: Harper & Row, 1966), 32-35, 65-67.

through inspired behavior worthy of an apostle. The dynamic of personal experience (in all its sensory, cognitive, and spiritual aspects) so essential to Quakerism positioned the Quakers in a uniquely creative way to explore the therapeutic effects on the insane of the social, built, and natural environments. Their insistence on the discovery of truth through observation and reflection also led them to value an empirical approach conducive to partnering with physicians and resulting in published accounts of therapeutic successes that were credible to scientists.

Early on, in the seventeenth century, Quakers were severely persecuted as a religious minority who defied the paying of Church of England tithes, the swearing of oaths, the deferential doffing of hats, and use of the formal "you" instead of the egalitarian and familiar "thou." They eschewed fancy dress and many popular pursuits of pleasure. Thus the late eighteenth-century Friends inherited a sense of kinship with the oppressed and despised groups in society. The Friends became dedicated activists in causes of social justice, including the abolition of slavery, educational and prison reform, and pacifism. Moral treatment of the insane became another focus of reform in this context.[78] Early Quaker leaders including Fox and William Penn spent long periods of time in prison. The fact that they used their confinement to write voluminously about their faith[79] may be significant in that they set a courageous precedent for diligently turning a potentially ruinous incarceration into a personal affirmation of divine blessing which in turn helped others to stay their spiritual course through adversity.[80] We see this constructive approach to the potential of

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[78] Anne Digby. *Madness, Morality and Medicine* (Cambridge: Cambridge University Press, 1985), 14.
[79] Trueblood, *The People Called Quakers,* 12-13.
[80] Trueblood finds the main difference between Puritans and Quakers to be the "added lightness and gaiety" the former bring to life. "Part of the glory of George Fox was that he knew how to walk cheerfully over the world." Ibid., 39.

the immediate present time and place, even in confinement, a century after George Fox's death in the establishment of the York Retreat, a new hospital for the Quaker insane.

As happened with Pinel, a tragic incident prompted constructive action. Hannah Mills, a Quaker widow from Leeds in Yorkshire, was committed to the York Asylum (a traditional public madhouse) for melancholia in 1790, only to die there six weeks later without having been allowed the comfort of visits by members of the York Quaker society. The York Asylum had refused requests for permission for visits to Mrs. Mills, and after she died it was unclear whether the treatment she received there had precipitated her death. William Tuke, a Quaker and tea merchant of York, was particularly moved by the tragedy of her demise and its circumstances. Tuke was already deeply involved in Quaker-inspired education in his home.[81] During discussions with his family, his daughter Ann reportedly asked, "Father, why cannot we have an establishment for such persons in our own Society?"[82] Known as an uncommonly determined man and respected by fellow Quakers as heeding his "inner light" (or the presence of Christ within him),[83, 84] William Tuke thereafter led efforts to establish an insane asylum exclusively for Quaker patients in Yorkshire, operated on a system of subscriptions and fee for services.

The resultant York Retreat proved to be revolutionary as a model of distinctive moral treatment. The father-led family served as an organizing social model for the Retreat just as the idea had been articulated within a Quaker family, posed in a question from child to father. Set apart from the rest of society within the community of the York Retreat, it was reasoned, Quaker patients would not have to suffer additional social, emotional, and

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[81] Digby, *Madness, Morality and Medicine,* 4-16.
[82] Ibid., 15.
[83] Barry Edginton, "The Design of Moral Architecture at the York Retreat." 16 *Journal of Design History* (2003) no. 2, 109.
[84] Trueblood, *The People Called Quakers*, 69-70.

spiritual distress from lack of support for Quaker ways and exposure to immoral habits. Providing treatment in a setting expressing Quaker values would help promote their recovery and assuage the considerable anxiety of their loved ones.[85, 86] It took six years to overcome the skepticism of fellow Friends, raise the funds, organize the governance, and build the facilities, but the York Retreat opened to patients in 1796.[87]

The moral character and authority of the staff, led by a non-physician, constituted important features in the moral treatment approach at the York Retreat.[88, 89] Given that the Quakers viewed the Retreat staff as witnesses to and participants in divinely authorized experiences of healing, the qualification of a highly evolved moral character was more important than scientific medical expertise.[90] Although initially somatic medical treatments like emetics, carthartics, bleeding, and drugs were attempted, their poor results prompted the Retreat to abandon them and fully embrace moral treatment methods. [91, 92] These included the social model and vocabulary of the family, light work and acceptable forms of recreation, and the use of praise and blame, rewards and punishment, to reform patients' behavior. The goal was to help the patients to develop or recover self-control and allow for divine healing. Close observation and discussions between Quaker staff and medical consultants (who were not always Quaker) led to the conclusion that moral treatment was effective. In accordance with Locke's views of fear in the role of education, the Retreat staff found that the

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[85] Grob, *The Mad Among Us,* 28.
[86] Grob, *Mental Institutions in America*, 43.
[87] Digby, *Madness, Morality and Medicine,* 16.
[88] Grob, *The Mad Among Us*, 28-29.
[89] Grob, *Mental Institutions in America*, 44, 46.
[90] Digby, *Madness, Morality and Medicine,* 26-27.
[91] Porter, *Madness: A Brief History,* 104.
[92] Grob, *The Mad Among Us*, 28.

"judicious" use of fear along the lines that parents used with children to prompt them to choose the better course of action worked better than a reign of terror.[93]

William Tuke's son Henry managed the Retreat after his father, and Henry's son Samuel helped to publicize the new meaning of "moral" treatment in his immensely successful 1813 book, *Description of the Retreat.*[94] Although a devout Quaker himself, Samuel Tuke wrote for a secular, medical audience, minimizing expressly Christian or Quaker substance and exhibiting the influence of Pinel. His *Description* made the details of the York Retreat widely available, prompting numerous visits by physicians from elsewhere in Europe and America. There was at the time a great need for empirical evidence of the success of moral treatment and Samuel Tuke's book was received, although with some criticism, largely as supporting the efforts that medical practitioners could undertake rather than as a practice reserved for Quakers.[95]

William Tuke and a Quaker architect from London, John Bevans, neither of whom had any medical expertise, together designed the Retreat.[96] As part of their research they visited St. Luke's asylum in London, established in 1751 as an attempt to provide better care than Bethlem but still plagued with the same problems.[97] Their letters reveal the painstaking care with which they approached the design to avoid past errors, seeking to balance comfort in a home-like atmosphere with security against possible fits of agitation or violence, within a modest budget. The Retreat window design provides an excellent example. Light was provided liberally in comparison to traditional madhouses. The windows had iron bars but they were hidden within wooden sashes. Windows were glazed at the bottom and open at

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[93] Charland, "Benevolent Theory," 65, 73.
[94] Grob, *The Mad Among Us*, 29.
[95] Charland, "Benevolent Theory," 74-75, 78.
[96] Edginton, "Design of Moral Architecture," 110-113.
[97] Digby, *Madness, Morality and Medicine,* 37-38.

the top to permit ventilation. The size of each pane was calculated to be too small to allow for elopement (the term used for escape throughout the movement) and cheap to replace if broken.[98] We will see the same care and consideration taken for heat, flooring, windows, width of hallways, placement of day rooms with respect to bedrooms, and supporting service facilities later in Joseph Rogers's designs for Longcliff.

The chosen setting was an eleven-acre farm on a rise providing views of the rural landscape. For the main retreat building Bevans and Tuke chose a simple, understated exterior style unlike existing neo-classical public asylums and intended to impart a sense of cheerful domesticity. Bevans cautioned that if the outside appeared prison-like it would have a negative effect upon the imagination.[99] This concern with the effects of the environment on the patients' minds pervaded the Retreat and the moral treatment movement in the nineteenth century as asylum after asylum was built on large plots of land set away from population centers. The immediacy of the countryside served as a therapeutic agent for restorative walks and drives in the open and unpolluted air (in contrast with city air) and serene views; for the healthier patients, visits to and from nearby towns were also therapeutic. Near the building a set of attractive gardens was planted in which patients could occupy themselves.[100, 101]

The total number of patients was at first limited to 30, allowing adequate space and attention for patients from staff compared to the admissions at Bethlem (app. 250), St. Luke's (app. 300), and York (app. 112).[102] Although Quakers avoided ostentatious ornamentation, the Retreat's interior was decorated with carpets, wallpaper and paintings

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[98] Ibid., 37-39.
[99] Edginton, "Design of Moral Architecture," 113.
[100] Ibid., 112-113.
[101] Digby, *Madness, Morality and Medicine,* 43-45.
[102] Ibid., 9.

selected to dispel gloominess.[103] The original use of heavy bolts on the doors of patients' bedrooms was found to remind them distressingly of previous confinements, so the mechanisms were subsequently encased in leather to soften the scraping sound and later replaced with mortise locks.[104] Although temporary seclusion was used on occasion for the most violent patients, it was viewed as a last resort.[105] Regular visits by the Society of Friends (including women) helped to prevent neglect of patients and provide social stimulation and spiritual encouragement to patients and staff.[106]

The therapeutic benevolence practiced conscientiously by the Quakers at the Retreat included both affective and ethical dimensions in the historical moment. The Quakers understood benevolence as an ethically sound, active practice which therapeutic providers engaged in and patients experienced affectively. In addition, it was a currency between and among Friends as a spiritual, religious expression of godliness. This therapeutic mode comports with the sense of the word "moral" at the time. In addition, the accountability of the Retreat staff for their stewardship and custody of the patients to the York Society of Friends meant that the therapeutic community was operated as an extension of the religious community and not an antithesis of it. The Quakers observed and to a large extent demonstrated with their therapeutic successes that patients who had lost their reason or control of their passions had not lost their spiritual humanity, which could be nurtured to help heal the mind, body, and soul.[107]

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[103] Edginton, "Design of Moral Architecture," 112.
[104] Digby, *Madness, Morality and Medicine,* 39.
[105] Samuel Tuke, *Description of the Retreat an Institution Near York, for Insane Persons of the Society of Friends, Containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases* (York: T. Wilson, 1813), 98. http://find.galegroup.com.proxy.library.emory.edu/mome/infomark.do?&source=gale&prodId=MOME&userGroupName=emory&tabID=T001&docId=U107019137&type=multipage&contentSet=MOMEArticles&version=1.0&docLevel=FASCIMILE.
[106] Ibid., 84.
[107] Charland, "Benevolent Theory," 67-68.

In the York Retreat, we see the fullest expression of the beginning of a new conceptual era for the insane asylum in which the facilities, land use, and social interventions were designed to create a total, multi-faceted environment intended to cure or alleviate the suffering of individuals afflicted with a complex, mysterious, and even more multi-faceted disease. The asylums of Bethlem, Bicêtre and Salpêtrière were established in older buildings not designed for moral treatment and obstructive of its methods, although they provided some evidence supporting the model of a set-apart hospital for the treatment of insane patients. In such frustrating settings did psychological treatment spend its infancy as an attempt to do better ethically and therapeutically than harsh somatic treatments.

We have seen that moral treatment evolved in France and England, on the basis of Lockean philosophy of mind, in existing asylums and a brand new experimental retreat. Religion was an unobtrusive but not forgotten source of the benevolence of Locke, Haslam, and Pinel and a driving force for the Tukes. There is no question but that William Tuke and the Retreat staff were Quakers first, not scientists; but their approach to moral therapy followed a protocol of sorts. They collaborated with physicians, closely attended to the patient, observed, reflected, and adapted their treatment of each patient over time. Is this not a description of a scientific approach? Haslam, Pinel, and their fellow men of science were scientists first and yet their careers in treating people suffering from mental illness expressed nothing if not compassionate benevolence. Indeed, benevolence was probably the most common principle to be found in the discourse on insanity and moral treatment in the early decades. References to Christian charity were not uncommon in their discourse.

The Quaker movement crossed the Atlantic and the continuing ties between the Pennsylvania and English Societies of Friends supported the influence of Quaker asylum practice in the States. In the eighteenth century the Quakers in Pennsylvania was

instrumental in establishing the Pennsylvania Hospital (with some public aid) for the poor sick and mentally ill in 1752, and in the nineteenth century, the Society of Friends became involved in more efforts to build asylums for the moral treatment of the insane. The Friends Asylum in Pennsylvania was opened in 1813, and an influential book by American Quaker Thomas Eddy was published in 1815, *Hints for Introducing an Improved Mode of Treating the Insane in the Asylum*, in which he credited Samuel Tuke's work. Quaker influence reached to the management of many more nonsectarian asylums. Samuel Tuke's *Description of the York Retreat* was made available in the United States, and Pinel's work was translated into English in 1806.

It was the passion of benevolence understood as a demonstration of Christianity that inspired and sustained the Quakers of York to overcome the obstacles to build the York Retreat. Perhaps the conception and execution of such a revolutionary vision required such inspired resolve and formidable dedication. Could the successes of the Quakers' moral treatments succeed without Quakerism, through moral treatment practiced by men of science? Would moral treatment, if practiced in the ideally designed setting, by individuals of virtuous character, succeed in curing insanity if a more secular, medical brand of benevolence and a passion for scientific progress drove the endeavor? This question arose in America as in Europe, for the scientific movement crossed the Atlantic in equal force as Quakerism. As we shall see in the next chapter, in the first half of the nineteenth century, American psychiatry developed as a profession which medicalized insanity and dominated the care of it at least for the dependent poor. Throughout the expansion of asylum-based moral treatment, benevolence would be the motivation cited by civic authorities, Christian reformers, physicians, and the associations representing them. Scientific progress would be seen as the means of achieving benevolent ends, and in a symbiotic fashion, the insane

asylum would become the means for scientific study of thousands of patients under moral treatment. Yet the public had to trust the state and the alienist profession to take custody and control of their loved ones. Benevolence served as a kind of currency inspiring such trust; in American society it would be expressed not only as a duty, but as the requisite character virtue for alienists, their hospital staff members, civic leaders, and even the hospital buildings themselves.

Chapter 3: Moral Treatment Movement in America

Turning to the nineteenth-century scene to trace a bioethical narrative of the moral treatment movement in the U.S., we will focus on three significant developments. These merit our attention because in them we see alienists and reform advocates advocate and express benevolence as a character virtue appropriate for themselves as physicians and civic leaders. We also see them employ language of moral duty in advocating care for the mentally ill, while struggling to demonstrate thrift as an accompanying virtue owed to the public as they accounted for their use of public funding and sought more. Since moral treatment included the agency of the hospital and its campus, they also projected the character virtue of benevolence onto an architecture for public mental hospitals, which was tempered by thrift.

These three major developments include the exponential, reform-driven growth in building and operation of a range of public benevolent institutions, including insane asylums; the professionalization of alienists and the consolidation of their authority and control over asylum medicine through the activities of a professional organization, the American Association of Superintendents of Institutions for the Insane (AMSAII); and the enormously influential design and management work of American Quaker alienist Thomas Story Kirkbride, M.D., which AMSAII promoted. Within this context, we can then turn to the development of moral treatment in Indiana as we narrow our focus further to examine the record of Joseph Rogers at Longcliff as a case study of an alienist's experiences in managing both benevolence and public accountability.

Public Benevolent Institutions

As the nineteenth century got underway in the United States, most people lived in the country, and while there were towns and cities, the young nation had no crowded, filthy cities yet, no London or Paris; there were no hospitals or priories built in medieval times to convert to asylum uses. American society had to confront the question of care for the mentally ill literally from the ground up, adapting European ideas to American experience. Eventually, nation-building, the vast availability of cheap land, and high demand would support a century of non-stop asylum building but this development did not happen immediately. Between home care and public mental hospitals, American society turned to the use of county alms houses and work farms to shelter and occupy mentally ill people. Separation of mentally ill individuals from their homes occurred routinely at the county level before state hospitals became the norm. In this way, these people were set apart and managed, but without treatment designed to promote recovery. They received only a custodial, bare-maintenance type of arrangement. Aside from being inexpensive, its main advantage was geographic: located within an insane person's home county, family and friends (if he had any) could visit with relative ease using the existing modes of transportation. This factor could ease the anxiety of family conflicted about giving up home care of the mentally ill family member. By contrast, the prospect of sending a loved one farther away to a state institution carried a greater burden of anxiety and required greater trust to accept.

Insane asylums were not the only form of American benevolent institution based on the asylum model as a carefully designed, set-apart environment for the confinement, support, and transformation of a specific population. As Rothman describes, this model was used and adapted for the confinement and management of orphans, vagrant children,

juvenile delinquents, and the very poor.[108] These institutions held a great deal more in common than the set-apart, confining, built environment. Philanthropists who promoted asylums believed that many of the same unstable social conditions created or contributed to the problematic status of the poor, the orphaned or poorly supervised children, the criminal, and the mad. The lack of well-defined social status, the vagaries of the marketplace, the immoral influences of the grog shop, prostitution, and fatherless families in American society in the early nineteenth century were all attributed causative force in placing needy populations in danger of even greater harm. Anyone not trained to counter the temptations and pitfalls of "the open, free-wheeling, and disordered life of the community"[109] was likely to lose his way, and the remedy for such dangerous lives was a sheltered, structured, and morally well-defined existence in an institution under the management of a superintendent.[110]

The most significant distinction between the asylum populations—i.e., whether or not society believed their deficiencies could be cured—also determined the purposes to which the corresponding asylums were put, and in turn, whether institutional planners employed design and engineering resources therapeutically or settled for the means to support custodial care alone. Some doctors proposed asylums especially designed for alcoholics with the goal of assisting them to recover through a program based on the idea that values and habits could be taught to the immigrant groups with which inebriation was most associated.[111] The developmentally and mentally disabled or delayed, however, then called "feeble-minded" or "idiots," were believed to be incapable of improvement or

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[108] David Rothman, *The Discovery of the Asylum,* rev. ed. (New Brunswick and London: Aldine Transaction, 2008).
[109] Ibid., 210.
[110] Ibid., 206-210.
[111] Yanni, *The Architecture of Madness*, 12-13.

recovery; hence medical superintendents tried to keep them out of their insane asylums to maximize space for those capable of a cure.

In this respect, the insane asylums had the most in common with the reformatory institutions for wayward children, in that the institution aimed confidently to transform the lives of its inmates through an ordered routine, not just to provide shelter and a sense of belonging to a social order. The moral treatment movement differed markedly, however, from such refuges on the issue of punishment. The reformatories used corporal and other forms of punishment aggressively to deter unwanted behavior such as independent action, and to incentivize desired behavior such as obedience to authority; but moral treatment prohibited punishment in the form of cruelty or physical pain for any behavior attributable to mental illness. This is not to say that asylum doctors did not employ seclusion or restraints in response to highly agitated or violent, dangerous behavior; but the reasons therefor were to protect against harm to the patient, staff, or other patients and not to teach a moral (ethical) lesson as the means to change voluntary behavior. At the child reformatory refuges, the superintendents practiced corporal punishment regularly, though theoretically as a last resort after trying moral suasion and withholding of meals. For example, at the New York House of Refuge, children inmates were whipped for questioning a guard's authority, talking, and bed-wetting; and were confined with ball and chain or leg irons for neglecting work for play, not coming when called, and being "artfully sly."[112]

In the middle of the nineteenth century, American social reformer Dorothea Lynde Dix (1802-1887) campaigned tirelessly across the country to persuade state governments to improve the institutional care for the poor mentally ill.[113]), Dix, a Unitarian, believed in the

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[112] Rothman, *The Discovery of the Asylum*, 231-232.

[113] Since women were not allowed to address state lawmakers, Dix provided written statements to likeminded politicians who read them aloud to the legislatures. Yanni, *The Architecture of Madness,* 52.

potential of each person to grow spiritually. Her campaigns enjoyed remarkable success. Employing moral rhetoric infused with Christian values of virtue and duty, Dix expressed the practical challenge of providing public care for the mentally ill as a profoundly significant opportunity to redeem the national character from a moral failure to care humanely for these unfortunate people. Largely as a result of the Dix campaigns, over 30 states constructed new mental hospitals—asylums for the insane—across the country, usually starting with one and adding more to meet the growing demand. The asylum became a new organizational form presided over in every aspect by a physician, the medical superintendent, who had to be or to become a specialist in asylum medicine to serve in this role.

Insane Asylums in Indiana

As early as 1832 the Indiana Legislature began to contemplate the need for publicly supported institutional care for the insane but it took over a decade for it to pass legislation that prompted meaningful action. In 1844 the Governor revived the issue and a revenue bill was revised to raise funds.[114] In January 1845, the Legislature passed an "Act to Provide for the Procuring a Suitable Site for the Erection of a State Lunatic Asylum," which appointed three men as a Board of Commissioners to find and purchase the land for the hospital, citing health and convenience as important criteria in their selection process. The Commissioners recommended that the facility be located in the state capital to enable the legislators to inspect it easily and "see the blessed fruits of their philanthropy": "it should be so situated that they can exercise a guardian care over it—to guard against, detect and correct abuses, if any arise."[115] It happens that Indianapolis is also located in the geographic center of the

[114] Henry M. Hurd, Volume II, *Institutional Care of the Insane in the United States and Canada* (Baltimore: Johns Hopkins Press, 1916-17, reprinted New York: Arno Press, 1973), 322.
[115] Ibid., 322-323.

state, so that aside from the central counties, no one region of the state could be seen as unfairly advantaged with easier access to the asylum for county authorities and families of patients. Thus Indiana was already taking serious steps toward the construction of its first public hospital for the insane when Dorothea Dix began her two-year county-by-county tour of existing arrangements for these vulnerable people in the state in 1845.

Her reports, "Jails and Poor Houses," were published in installments by the *Indiana State Journal* in Indianapolis beginning in August 1847. For the most part, Dix described the buildings, settings, conditions, and residents of the facilities in a factual, detached manner which allowed the reader to form his own conclusions. The sheer repetition of deficiencies and the volume of inventory throughout the state's counties provided a great deal of evidence for the public to conclude that the state of affairs was unacceptable. Dix gave well-intentioned keepers the benefit of the doubt and noted whenever individual efforts were admirable and exemplary, but she did not allow these exceptional cases to justify the general lack. Her commentary flowed from the point of view of an observant reporter with the public's best interests at heart, and with that perspective, she made it clear that the public's beneficent intentions were not being comprehensively fulfilled in spite of the money being exchanged, and that the good examples of a few keepers should not be accepted as evidence of a successful status quo. The public should get more, and consistent, value for its money, Dix advised. "The people at large rarely show selfish or parsimonious dispositions when appeals are made in behalf of suffering humanity. It is not want of friends either, but the injudicious application of these which creates such unfortunate results."[116] The problem was not the amount of money spent; it was the system in which it was spent.

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[116] Dorothea L. Dix, "Jails and Poor Houses," *Indiana State Journal* (1845-47), Volume VIII.

At times, Dix abandoned the objective position and gave voice to her opinions in dramatic and eloquent terms. Jefferson County poor house, for example, she found to be:

> …poor in the most literal and various sense; how shall it be described? -- not as the home, nor the refuge, nor the well-ordered, comfortable asylum for the friendless, the infirm, the necessitous. It affords no comfort, no consolation to the unfortunate; they may go thither it is true; they will not be left actually to starve; they will not be quite destitute of clothing; they will not really perish for want; but when I was there the last of July, I thought I had rarely seen any establishment of the kind so squalidly wretched, so comfortless and neglected. I found seven inmates; one idiot, and several advancing to imbecility.[117] (Emphasis original.)

The fact that the Indiana General Assembly had passed a law appointing a board of commissioners to acquire land for the location of a state lunatic asylum[118,119] provided Dix the basis for occasional references to relief, at least for the insane, being near, with the goal of a return home to their families.

> I heard of and saw in Jefferson county many sad cases of insane patients; these will find partial or complete bodily and mental relief when the Hospital for that class of sufferers in Indiana shall be completed. By another year less afflictive scenes will be found in many families, and peace restored, and misery assuaged, where now desolation and sorrow reign…[120] The noble Hospital, which the humane and wise of the State have used their influence to establish, and which the citizens have cheerfully taxed themselves to raise and complete, will soon unfold its gates to the many sick and suffering insane whose friends are waiting anxiously to place them in a situation promising remedial care and recovery.[121]

According to Dix, the purpose-built asylum would express the public's own virtuous intentions and fulfill its moral duty to care for the sick while offering a real cure.

Both Dix and the editors of the *Indiana State Journal* emphasized the generosity of the public; the massive and systemic deficiencies noted were attributed to poor management, not

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[117] Dix, "Jails and Poor Houses," Volume VII.
[118] Philip M. Coons and Elizabeth S. Bowman, *Psychiatry in Indiana – the First 175 Years* (Bloomington: iUniverse, 2010) 9.
[119] Hurd, *Institutional Care of the Insane*, 322.
[120] Dix, "Jails and Poor Houses," Volume VII.
[121] Dix, "Jails and Poor Houses," Volume III.

to stinginess or lack of compassion. Her call was intended to help the public to realize that the time had come for a well-developed system of benevolent charitable institutional care for the poor and the insane, which required greater administrative oversight as well as environments designed and built to prevent illness and to ensure safety. Dix also called for better constructed and maintained county jails, citing "the obligations of the citizens to have them so constructed that the health of those who from time to time forfeit their liberty shall not be impaired."[122] The dungeons of county jails sometimes housed insane persons, and not necessarily incidentally to some criminal prosecution; for example, the jail-keeper in Posey County at Mt. Vernon "observed that he was liable to have charge of insane persons, when any cases occurred which were dangerous to be at large, or too violently affected to be restrained at home."

Dix found among the poor many insane persons, "indeed no county is without representatives of this suffering class."[123] Shockingly, in some counties, the custody and labor of poor persons were auctioned to the lowest bidder.[124] Apparently this custom was intended to keep the cost to the county taxpayers as low as possible while providing a home, care, and work to the poor as well as cheap labor to their winning-bidder master. In this manner some insane persons were also auctioned off and kept. "The poor in Warren county are sold to the lowest bidder," Dix quoted her county source as reporting, adding their justification that "care is taken that none but men of good character and benevolence are employed to support and provide for them."[125] It is interesting to note that the colloquial term Dix used for this arrangement was that the persons were sold, although slavery was not

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[122] Dix, "Jails and Poor Houses," Volume VI, re Grant County jail at Marion, Indiana.
[123] Dix, "Jails and Poor Houses," Volume V, regarding Huntington County.
[124] Dix, "Jails and Poor Houses," Volume VI, regarding Grant County.
[125] Dix, "Jails and Poor Houses," Volume III.

legal in Indiana; the reality of the dependency of the persons rendered their loss of dignity, status, and rights similar to that of slaves at auction. The good fortune of such care found in Warren County was not duplicated in Switzerland County. There in the Poor-house located on a 160-acre county farm, Dix reported, lived five dependent residents:

> …a blind man and his wife occupied one room, and in this was chained to the floor a furiously excited crazy woman; between whom and the other female, said my informant, were 'daily right hard fights" and some who saw this shocking exhibition between the unfortunate insane, and the creature of ungoverned passions, 'think it excellent fun!'…The lowest bidder, I was informed, has the farm; of course this reveals the fact that special qualifications for filling so difficult and responsible a situation, have no part in this transaction.[126]

Dix reported to the state legislature in 1848 that some 900 persons were kept in county jails and poor houses across the state, and yet the capacity of the first state hospital was limited to 250,[127] an early indication of the inadequacy of the state's understanding of the actual demand. At this time there were 20 state hospitals for the insane and several private hospitals in 19 states; a year later, Indiana opened its first public mental hospital in Indianapolis.[128] Named the Indiana Hospital for the Insane, this institution served as the sole state mental hospital for forty years, and while it was expanded many times it was never adequate for the population's demands as long as it was the only such resource in the state.

For the purposes of this study, the Indianapolis hospital is also important as the place where Joseph Rogers first served as a medical superintendent, from 1879 to 1883[129]. It was here that he made the permanent transition from ophthalmology and general medicine to asylum medicine. Rogers' attraction to ophthalmology, with its transformative use of optical technology, preceded his turn to the application of medical knowledge and design to

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[126] Dix, "Jails and Poor Houses," Volume VIII.
[127] Yanni, *The Architecture of Madness,* 14.
[128] Hurd, *Institutional Care of the Insane,* 339.
[129] Coons and Bowman, *Psychiatry in Indiana,* 114.

the transformative use of the built environment. Here he observed the limitations and advantages of the lunatic asylum designed in the most famous manner of the nineteenth century, the linear or Kirkbride plan, and based on that experience Rogers advocated for the use of alternative designs in the next mental hospitals to be built in Indiana.

AMSAII, Kirkbride, and the Linear Plan

The development of a cadre of alienists known as medical superintendents practicing asylum medicine (the hospital being inseparable from the treatment) went hand-in-hand with the first specialized organization of physicians in the United States. In 1844, three years before the American Medical Association was founded, thirteen American alienists founded AMSAII, an organization which became a highly successful mechanism for mutual support, the promotion of the profession as legitimate purveyors or unique expertise, and the study and refinement of moral treatment. In 1892 its name changed to the American Medico-Psychological Association to allow for the membership of assistant physicians along with medical superintendents, and in 1921 its name changed again to the American Psychiatric Association, as it is known today.[130] Annual conferences were held at cities around the country near members' asylums to facilitate collegial site visits. One-year presidencies gave a broad group of members the opportunity to draw national and international attention to their opinions and the work of their hospitals. AMSAII's other critical activity was its publication of the *Journal of Insanity* in cooperation with the New York State Lunatic Asylum at Utica, whose medical superintendent, Amariah Brigham, served as editor-in-chief for decades. This journal, which became the *American Journal of Psychiatry* in the twentieth

[130] American Psychiatric Association website, http://www.psychiatry.org/about-apa--psychiatry, accessed August 6, 2014. The APA notes at this website that its membership exceeds 35,000.

century, served as a forum for sharing ideas, opinions, research, case histories, and reports from practitioners and travelers abroad, on the subject of efficacious hospital design and management and other topics of mutual specialized interest.

The technical focus of alienists on creating the right built environment to deliver curative treatment helped them to reserve the sphere of hospital design to themselves. By mid-nineteenth century this expertise became known as "medical engineering" and its physician-practitioners as "medical engineers." In 1851 and 1852, at the consecutive annual AMSAII meetings in Philadelphia and Baltimore, the members adopted two sets of propositions based on the work of Thomas Kirkbride as the organization's standards for hospital design[131] and management,[132] intended to guide the members and their state governments in the process of establishing new or expanding old public mental hospitals. These statements serve as an executive summary of Kirkbride's master work, published in 1854, entitled *On the Construction, Organization and General Arrangements of the Hospitals for the Insane* and are included as appendices to that work. It is not surprising that AMSAII and Kirkbride joined forces over architectural and managerial standards. With Kirkbride's work and national reputation, AMSAII had the opportunity to exert widespread influence across the country and beyond, and for Kirkbride, AMSAII provided the vehicle to communicate his ideas about how to implement proper moral treatment.

Kirkbride's 1854 work comprises two parts for construction and organization, each expanding on elements of the hospital standards. It is easy to detect a keen consciousness of public scrutiny in this document, an awareness Kirkbride shared with alienists working for public institutions generally. This concern of alienists with winning and keeping the public's

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[131] Twenty-five items in 1851.
[132] Fourteen items in 1852.

trust and the state's financial support provided a counterpoint to benevolence throughout the nineteenth century, and became if anything more acute as overcrowding undermined the successes of moral treatment. At mid-century Kirkbride and AMSAII found it politic to try to persuade the public that medical superintendents deserved a monopoly on hospitals for the insane based on their collective experience. He noted that experience to date had reached a point of general acceptance of the primary influence of the location, design and appointments of the insane hospital on the likelihood of recovery for the curable and on the mental and physical wellbeing of the incurable. Verging on the defensive, Kirkbride wrote that this experience should not be questioned as material worthy of publication.[133] Tension between the need to exude confidence as experts and the insecurity of dependency on the public's trust runs through this document and much of the contemporaneous alienist literature.

The AMSAII standards, not surprisingly, include this directive: "No hospital for the insane should be built without the plan having been first submitted to some physician or physicians who have had charge of a similar establishment, or are practically acquainted with all the details of their arrangements, and received his or their full approbation."[134] Kirkbride uses the term "high character" to mean a refined genre of architecture, purpose-built for the care of the insane and drawing on the empirical experience of moral treatment practitioners. He cites failed hospital designs as evidence supporting the idea that alienists must be consulted because of their expertise in the special characteristics of the patient-occupants.[135]

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[133] Thomas S. Kirkbride, *On the Construction, Organization and General Arrangements of Hospitals for the Insane* (Philadelphia: Lindsay & Blakiston, 1854), 2-3. http://galenet.galegroup.com.proxy.library.emory.edu/servlet/Sabin?af=RN&ae=CY108090432&srchtp=a&ste=14.

[134] Kirkbride, *Hospitals for the Insane,* 76.

[135] Kirkbride, 3-4.

To support the professional consensus claim, Kirkbride employs scientific, economical, and moral (ethical) arguments that express both benevolence and thrift as character virtues appropriate for a public servant. In the introductory section, Kirkbride presents several scientifically supported grounds justifying the moral treatment hospital which are by now familiar to us. Unlike other illnesses, he advises, insanity is better treated by strangers than family, and proper treatment in a hospital soon after the onset of illness results in 80 to 90 percent chance of recovery, while few neglected or poorly treated patients get well.[136] The case for the "liberal provision" of public mental hospitals seems clear given these figures, but Kirkbride calls also on the conscience of the readers to recognize the "obvious duty" of friends and public authorities "of placing them in a place of security, not only to promote their restoration, but for the protection of the public." Duty appears not only to operate for the good of the ill but for the good of the healthy and "innocent and unoffending" members of the public. And even if treatment cannot cure all patients, he argues, it is immoral to deny them the benefits of comfort.[137]

Every state took financial economy seriously, and it plays a recurring role in Kirkbride's plans and in asylum-medicine literature generally because of the predominance of public insane hospitals in AMSAII membership. The challenge was to deliver moral treatment without giving the public the impression that money was being wasted.[138] Sometimes, Kirkbride seems to have relied on an air of professional authority to persuade. For example, with respect to the question of whether those deemed incurable should be kept, and more cheaply, in county hospitals rather than state institutions, and whether the former should be associated with poor/alms houses, Kirkbride concludes, "nothing could be

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[136] Kirkbride, *Hospitals for the Insane*, 1-2.
[137] Ibid., 5.
[138] Ibid., 4.

more improper or injurious than such an attempt to separate the supposed curable and incurable insane."[139] Yet he cannot resist adding the thrift argument, asserting that no poor insane patient can be cared for better or at less cost than in a well-managed asylum with a resident medical superintendent.

At other times Kirkbride appears to rely most heavily on ethical arguments to justify the public expense; for example, he cites the morality and injustice of denying the ill comforts at least partially on the grounds that these individuals have only been unfortunate to become insane. The mentally ill are morally innocent where the etiology of disease is concerned.[140]

A Closer Look at the Kirkbride-AMSAII Asylum Model

Outdoor Standards

Although alienists debated the relative merits of architectural models for the hospital buildings throughout the century, they agreed on the appropriate use and style of the hospital land and its power as a therapeutic agent. AMSAII set forth standards for the relationship between the natural environment and the built structures, and between the hospital location with respect to population centers. Kirkbride described the hospital as having and possessing the land, not as merely set on it; the purposefully organized grounds constituted an inseparable element of the therapeutic hospital. "Every hospital for the insane should be in the country,"[141] within two miles of a large town, easily accessible, having at least 50 acres of land "devoted to gardens and pleasure-grounds for its patients."[142] This

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[139] Ibid., 5.
[140] Ibid., 4-5.
[141] Ibid., 76.
[142] Ibid.

much strongly echoes the eighteenth-century York Retreat with its picturesque grounds and proximity to town to enable the better-behaved patients to enjoy walks to and fro. The insistence on a rural location also accorded with a growing sense that the march to civilization could cause insanity or at least predispose people to mental disorders. A leading medical superintendent, Edward Jarvis, M.D. wrote that mental illness is "part of the price we pay for civilization."[143] This belief was pervasive throughout the second half of the nineteenth century, as the United States became increasingly urbanized and industrialized, its population exploded with immigration, and ties to the old agrarian way of life eroded and disappeared. A significant portion of hospital acreage was expected to be left in its natural state or enhanced through the naturalistic practices of landscape architecture, which involved creating natural-looking views, asymmetrical plantings, and curved paths to mimic and even improve upon the organic shapes in Nature. The outdoor sensory experiences were intended both to stimulate and soothe the patients' minds and strengthen their bodies through mild to moderate exercise—walks accompanied by attendants, in most cases. The formalistic symmetry of the building designs contrasted starkly with the naturalistic theory and presentation style of nineteenth-century landscape design, but the two domains complemented each other: indoors life was highly socially structured and orderly; outdoors it was looser, closer to the balanced systems of the natural world.

Although protected somewhat from public view by distance, AMSAII and Kirkbride advised that the dignity of the patients required that whenever possible, a wall should surround the pleasure-grounds, "so placed as not to be unpleasantly visible from the building."[144] Kirkbride explains that the primary purpose of such a wall was to keep the

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[143] Rothman, *The Discovery of the Asylum,* 112.
[144] Kirkbride, *Hospitals for the Insane,* 78.

public out, to "protect the patients from the gaze and impertinent curiosity of visitors."[145] Secondarily and still importantly, a wall would deter elopements and protect patients from wandering off into danger while "enlarging the liberty of the insane."[146]

The hospital land also supported the machinery for such practical necessities as laundries, crop fields, ice houses, pump houses, water pipes, and farm buildings. Given that good hygiene and nutrition were components of the healthy life provided at the hospital, AMSAII and Kirkbride emphasized the proper attention required to hospital water supply required for bathing and cooking (as well as dousing fires): "Means should be provided to raise ten thousand gallons of water, daily, to reservoirs that will supply the highest parts of the building."[147] In that day, sufficient supply of water piped in from the adjacent land with sufficient pressure could not be taken for granted but had to be asserted as a basic minimum requirement for keeping patients, staff, and buildings clean. This was so important that Kirkbride believed it transcended the entire issue of cost: "An abundant supply…should be secured whatever may be the cost or trouble required to effect it."[148]

Indoor and Managerial Standards

Some outdoor standards, such as water, were related to indoor standards. AMSAII asserted that drainage "should be under ground, and all the inlets to the sewers should be properly secured to prevent offensive emanations."[149] In other words, the therapeutic power of the place would suffer from the smells of open sewage, which in some European

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[145] Ibid., 6.
[146] Ibid., 9.
[147] Interestingly, the call for abundant water supply at that time meant that water tanks were placed in the highest part of the building so that gravity could assist the flow; this fact made it desirable from an engineering standpoint to have a prominent tower or story somewhere in the hospital. The imposing height of that part of asylum roofscapes thus resulted at least in part from the solution to an engineering problem, not a stylistic one.
[148] Kirkbride, *Hospitals for the Insane,* 8.
[149] Ibid., 77.

cities at the time posed a common public health problem, not to mention daily displeasure.[150] AMSAII insisted that every ward, let alone building, should have in it a water-closet (room with plumbed, water-supplied toilet) and bath-room (literally a room with bath tub separate from the water-closet),[151] which constituted more advanced facilities than many residential and commercial buildings of the time that continued to use outhouses. It was imperative to master this basic engineering problem to create the comfortable, pleasant living environment that would help to restore balance to unbalanced minds and to earn the confidence of the public and the government. Who would trust a hospital permeated with the stink of human waste?

The landscape surrounding each hospital created soothing views for patients to take in from indoors. The "wards for the most excited class [group of patients] should be constructed with rooms on but one side of a corridor, not less than ten feet wide, the external windows of which should be large, and have pleasant views from them."[152] Further, the outdoors supplied the air to the hospital interior, and here the asylum design standards expressed the miasmatic theory of disease that lingered in the U.S. mid-century—i.e., the notion that offensive odors caused or spread disease.[153] Per Kirkbride, every room should have some kind of window "communicating directly with the external atmosphere."[154] Indeed the circulation of fresh air was considered essential for good health both mental and physical, and since this would be impracticable belowground, the AMSAII standards include

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[150] S. B. Sutton, ed., *Civilizing American Cities: A Selection of Frederick Law Olmsted's Writings on City Landscape* (MIT, 1979), 27-32.
[151] Kirkbride, *Hospitals for the Insane,* 77.
[152] Ibid., 78.
[153] Yanni, *The Architecture of Madness,* 33-34.
[154] Kirkbride, *Hospitals for the Insane,* 77.

an emphatic prohibition: "No apartments should ever be provided for the confinement of patients, or as their lodging-rooms, that are not entirely above ground."[155]

The other indoor AMSAII-Kirkbride standards—too numerous and technical to review here—were likewise based on concerns about safety, (fire-proofing, preventing falls and jumps), durability (material for floors, staircases, and walls), economy, and comfort for the patients.

The social organization within the hospital bears examination for the evidence it gives of the importance of well-ordered human and professional relationships to concepts of moral treatment and cure. These relationships include the categories of patient-to-patient, superintendent-to-staff, staff-to-patient, patient-to-visitor, and staff-to-visitor. Limiting the number of patients and the staff-to-patient ratio set the foundation for the treatment model: the patient population should not exceed 250, and ideally should remain at 200, with a staff-to-patient ration less than 10:1.[156] The fact that this maximum was quickly and far exceeded in virtually every public insane asylum constitutes one of the most significant facts in the history of the moral treatment movement, for it means that the model based on a special environment with purposeful human behavioral interventions suffered from this grave disadvantage from the start. The overpopulation resulted in unintended stress on the capacities staff and the physical plants, reducing the quality of care. Since increasing numbers of admitted patients were elderly, afflicted with dementia, and resistant to cure, the entire model was subjected to a transformative pressure to expand from its cure-based origins to include custodial care for the chronically ill. From a bioethical viewpoint, it also

[155] Ibid., 77.
[156] Ibid., 4, 76.

means that moral-treatment advocates had to engage with thrift-driven arguments that undermined the benevolence principle and the quality of care in favor of minimizing cost.

Although he did not, and likely could not, foresee that massive immigration would contribute to the transposition of the moral treatment model, Kirkbride did contemplate the problematic dynamic that springs up when both human and environmental interventions cooperate in providing care. He expresses some anxiety that too great reliance on the specially designed technical infrastructure (walls, floors, windows, etc.) for patient care could lead to complacency with respect to the higher importance of staff exercising constant vigilance over patients.[157] "The presence and watchfulness of intelligent attendants must still be the grand reliance to prevent the escape of patients."[158] In other words, he worried that moral treatment would neglect the primacy of the human element and become prison-like through over-reliance on the built environment to contain the behavior of the patients. We see this as a recurring theme in the bioethical history of the moral treatment movement throughout the nineteenth century: a tension between wanting human agency to remain paramount, as the most effective and meaningful means of cure, and recognizing the limits, sometimes severe, of asylum staff to deliver care that consistently lives up to high standards. It is this dynamic in which Joseph Rogers worked throughout his career at Longcliff, and we shall see that his extraordinary commitment to benevolence expressed itself in his direction of both human and technical agencies. Where human resources reached their limits, as in their power to prevent every elopement, Rogers reminded others that the hospital was not a prison and the solution to the problem of elopements lay not in more locks but in the

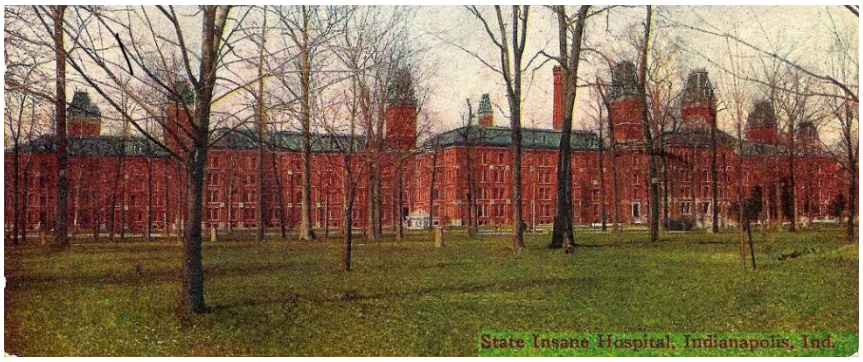
[157] Ibid., 9.
[158] Ibid.

diligent search for and eventual return of the eloped patient to the hospital.[159] The engineering dimension of moral treatment, as alienists became increasingly professionalized and educated in sciences, invited the channeling of passion and intellect into creativity like that of Kirkbride and Rogers. They expressed human and professional benevolence by engaging in pragmatic strategies and control over every detail of design and construction.

Although Kirkbride's name became synonymous with the "linear" building plan he advocated, the design was not strictly linear.

> A large hospital should consist of a main central building with wings…The wings should be so arranged that, if rooms are placed on both sides of a corridor, the corridors should be furnished at both ends with movable glazed sashes, for the free admission of both light and air.[160]

This prescription translates to a stepped, receding progression of wings extending backward



and parallel to the central building, in which the superintendent and his family would live, and staff would receive visitors and occupy offices. "Linear" looked more like a very wide, shallow letter "U" than a line. [161] The accompanying image of the main asylum at Indianapolis c. 1890[162] (then used as the men's ward) exemplifies a Kirkbride plan. A typical

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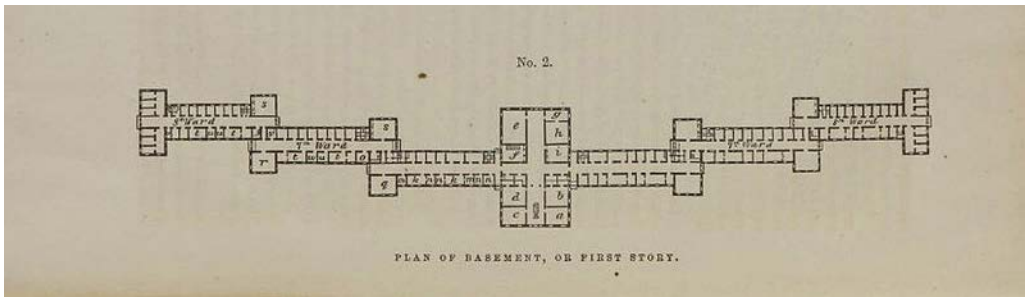
[159] Letter from Joseph G. Rogers to Della Beason, November 22, 1894; Box 17-J-3, letter-book, Indiana State Library, 164.
[160] Kirkbride, *Hospitals for the Insane,* 77.
[161] Asylum Project website, http://www.asylumprojects.org/images/5/56/CSHpc3.jpg. Accessed October 8, 2014.
[162] Ibid.

Kirkbride floorplan shows at a glance the unity, symmetry, and strong horizontality of his model:[163]



Kirkbride's insistence on this configuration for large hospitals bears examination. Why did he believe so strongly that this design surpassed any others? Indeed, in spite of the AMSAII's adoption of Kirkbride's principles, several other robust plans remained in use and a great deal of space in the *American Journal of Insanity* was devoted to varying opinions on the subject over the course of the century. The major competitors included: the cottage plan, in which patients and staff lived in home-like small structures on the campus, sometimes with independent kitchens and other times with a central dining room; the radiate plan, a hub-and-spoke model with recreation yards located between wards around the central building; and the pavilion plan, with a central building for collective activities like dining, cooking, and recreational activities, and large block-like dormitory buildings interspersed around it. A minority alternative model was community living, where patients boarded with families in a village (most famously in Gheel, Belgium). With the exception of community living, all of these plans shared the need to separate some supporting utility buildings from the central living quarters and the imperative of a natural landscape, such that the entire collection comprised a coherent whole on its own well-bounded campus.[164]

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[163] The Alienist's Compendium. http://alienistscompendium.com/?p=295. Credits www.CornellPsychiatry.org. Accessed October 8, 2014.
[164] Yanni, *The Architecture of Madness,* 79-104.

It is well accepted that at a time when most Americans lived in rural areas and rarely had cause to see or use a state-owned and operated building, a large, symmetrical, civic structure tended to communicate power, authority, and deference. What is less clear is the reasons why Kirkbride and his camp insisted on the monolithic whole. What could be so important about one connected building with a central administrative block if others could reasonably demonstrate that detached buildings on a shared campus could also function effectively to deliver moral treatment? The answer may lie in the historical moment: the tension between the alienists' ambition to become the unquestioned authority and practical manager of hospital-based treatment, and the public's resistance to placing their loved ones in a facility not only outside their home but outside their county, in the care of strangers.

At the time, most Americans would rarely see a state-government-owned edifice. Comparing the "linear" plan to a detached plan, the obvious distinction becomes clear: in the Kirkbride plan we can easily see the structural unity of the hospital. With whatever emotional and symbolic power the visual and spatial experience carries to the visitor, one common association or conclusion is that the patient wards exist harmoniously under the central, constant, in-dwelling authority of the state and the medical superintendent. Families could be comforted by the immediate proximity of doctor to patients under one roof, the connectedness of the people living in one large but highly organized, efficient, and largely self-contained system. With such height as the tallest roof commanded (usually atop the central administrative building) and such breadth as the ward wings created sideways, the image of structural unity communicates to the observer on the ground a sense of scale that could impress and even intimidate. A patient's relative from a nearby farm or a trustee making an inspection of the premises could hardly fail to conclude at some level that here

state power, authority, civic investment, and protective, organized shelter came together in force.

Two historical architectural models predating the Kirkbride plan deserve mention in this context. The first, as Yanni has noted, the "linear" plan with its central pavilion and connecting internal corridors harkens back to the eighteenth-century English country house with its long "galleries" originally used to display paintings, and its command of the surrounding lands for pleasure grounds, gardens, farms, and hunting country. Some English country houses were converted into asylums; their galleries became long corridors for patients to walk in and to circulate fresh air. The visual impact of such residences owned by aristocrats who usually exerted political control over their tenant neighbors also resembles the impression of state and class authority projected by the Kirkbride elevations. The second architectural forbear, which Joseph Rogers mentioned in his 1900 speech to AMSAII, was the European monastery, with its long corridors and sense of totally controlled environment and moral (ethical) authority.[165]

By contrast, a collection of detached buildings, no matter how formally arranged, looked more like residential areas—farms, villages, towns. See for example below two views:

[165] Joseph G. Rogers, "A Century of Hospital Building for the Insane," LVII *American Journal of Insanity* (July, 1900) no. 1, 3.

one of the rear of the Administration building[166] and the other a view of the lake and detached ward and utility buildings at Longcliff:[167]

[166] Rear view of the Longcliff Hospital Administration building. Photograph of postcard, c. 1905, courtesy of the author.
[167] Lake at Longcliff Hospital. Photograph of postcard, c. 1900, courtesy of the author.

All of the sensory perceptions created by the custom-made environment operated, in moral treatment theory, on the patients' minds, helping them to reclaim mental balance, stable moods, and bodily vigor; or at least to improve these conditions.

The AMSAII and its members carried on a related debate throughout the nineteenth century: whether to separate the "curable" and "incurable" classes (groups) of patients socially and physically by means of separate wards and segregated activities, and even, in the extreme question, in separate institutions. This question became more urgent as the numbers of patients needing admission swelled in the latter half of the century because the higher concentrations of patients exacerbated the conflicts between them. Kirkbride came out strongly as an advocate of separation based on classification, for therapeutic purposes, but not including "incurable" as a class. Importantly from a bioethical perspective, he questioned the wisdom, compassion, and modesty of judging some patients to be incurable:

> The first grand objection to such a proposition [of providing separate institutions] is, that no one can say with entire certainty who is incurable; and to

> condemn any one to an institution for this particular class is like dooming him to utter hopelessness…It is somewhat presumptuous for us to say that a recovery is impossible in any case.[168]

Here we detect a profound commitment to professional humility and civic benevolence as well as to a scientific habit of mind which not only demands persuasive evidence as a prerequisite for a conclusion carrying dire consequences, but employs the language of the scientific method to express the probability of those consequences occurring. At the same time, he condemns the economic driver that tends to undermine the quality of benevolent care:

> When the incurable [by which Kirkbride meant the chronically ill who appear resistant to cure] are in the same institution as the curable, there is little danger of their being neglected; but when once consigned to receptacles especially provided for them, all experience leads us to believe that but little time will elapse before they will be found gradually sinking, mentally and physically, their care entrusted to persons actuated only by selfish motives—the grand object being to ascertain at how little cost per week soul and body can be kept together—and, sooner or later, cruelty, neglect and suffering are pretty sure to be the results of every such experiment.[169]

The better way lay in the judicious separation of groups of patients, eight for each sex, totaling sixteen, "to associate in the same ward those who are least likely to injure and most likely to benefit each other, no matter what may be the character or form of their disease, or whether supposed to be curable or incurable."[170] This principle meant, almost categorically, separating the most noisy, slovenly, and violent from the quieter, cleaner, and more self-controlled patients, usually locating the noisiest to the "back" wards farther from the center to better reduce the nuisance of noise. Patients would be assigned and reassigned to such classes depending on their progress or regress. With this approach, not only the

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[168] Kirkbride, *Hospitals for the Insane,* 59.
[169] Ibid.
[170] Ibid., 58.

beneficial potential of mutual support amongst patients could be fulfilled, but by the mechanism of extroverted social engagement patients could restore reality to their own minds: "Patients are often much interested in the delusions of their neighbors, and by their efforts to relieve the afflictions of others, frequently do much towards getting rid of their own."[171] While Kirkbride does not elaborate on this mechanism, it brings to mind Pinel's observation of similar phenomena, which he explained as the patient's realization that if another patient's beliefs were delusional, so could his own be.[172] This cognitive perspective on the logical potential of one's own condition being irrational could be the mechanism responsible for the same effect Kirkbride observed. On the other hand, perhaps the social experience of empathy among fellow sufferers helped patients to heal. Vincent Van Gogh, the Impressionist painter, wrote in 1889 upon his voluntary admission to an asylum in France for delusions of persecution:

> Though here there are some patients very seriously ill, the fear and horror of madness that I used to have has already lessened a great deal. And although here you continually hear terrible cries and howls like beasts in a menagerie, in spite of that people get to know each other very well and help each other when their attacks come on.[173]

Indiana Politics and Hospitals for the Insane

Unfortunately, classification of patients and the violent symptoms of some seriously ill patients combined to make the "back wards" of some state mental hospitals synonymous with terror in the minds of the patients and the public. Indiana was not immune to this plight and politics in state government, especially the patronage and spoils practices of parties in power, severely exacerbated the poor quality of care at the Indianapolis asylum

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[171] Ibid.
[172] Pinel discusses this phenomenon in the context of the coincidence of several patients, each of whom believed he was the king, running up against the possibility of their own delusion.
[173] Sander L. Gilman, *Seeing the Insane* (New York: J. Wiley, 1982), 218.

until the last quarter of the nineteenth century.[174] Politics complicated the establishment of asylums in Indiana and posed challenges to the control of the medical superintendents over the staff they could hire as late as the last quarter of the nineteenth century. Dr. Henry M. Hurd, who served as the medical superintendent at Pontiac (Michigan) State Hospital before joining the psychiatry faculty at Johns Hopkins, edited a detailed account of the political and administrative aspects of Indiana asylums in the nineteenth century which was published in 1917.[175] One of the authors who contributed accounts of the Indiana asylums was Samuel E. Smith, M.D., who spent three years as an assistant medical officer under Dr. Rogers at Longcliff (1888-1891)[176] before taking up the post of medical superintendent of the Eastern Indiana Hospital for the Insane near Richmond. Dr. Smith's accounts provide a good deal of insight into the effects that politics and legislation had on the implementation of the moral treatment movement in the state asylums. The freedom of the medical superintendents to hire and fire staff and direct hospital operations; the prioritization of classes of patients for admission; the rules for commitment, furlough, discharge, and readmission; the compensation available for staffing; the funding for board and recreational activities for patients; and the timeliness and scope of expanding facilities to meet demand all were affected by partisan politics and legislation. The quality of moral treatment depended on the authority of the medical superintendent to ensure adherence to its principles, and if asylum attendants were hired based solely on their party membership as a form of patronage, as they were at the Indianapolis asylum for periods of years before legislation eliminated the practice, the chances of successful therapy were low indeed.[177] Given such obstacles, it is

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[174] Albert Thayer, *The Indiana Crazy House* (Indianapolis: 1886), 4-5 (unnumbered pamphlet pages).
[175] Hurd, *Institutional Care of the Insane.*
[176] Ibid., 309-322, 359.
[177] Thayer, *The Indiana Crazy House*, 4-5.

not surprising that the delivery of moral treatment to the people did not more closely approximate the ideals conceived by its proponents.

During the last quarter of the nineteenth century Indiana's benevolent and correctional institutions were administered by individual boards consisting of three members. Members were usually appointed by the Governor although the Legislature took over this role during periods of high partisanship when the Governor and Legislature belonged to opposing parties. Predictably, this arrangement interfered with the professional administration of the institutions, meaning that the proper implementation of moral treatment hung in the balance.[178] In 1883 the state legislature took a very unpopular action depriving the Governor of appointing power and creating a system of three boards of two members each to oversee the insane hospital, the asylum for the blind, and the institution for the education for the deaf and dumb; the board members were to be elected by the Legislature (one for each of the Indianapolis institutions) and all overseen by a president also elected by the Legislature. All members belonged to same political party. Following much scandal and public opposition, this initiative was repealed.[179]

In 1889 the state Legislature enacted a new law creating a board of state charities with advisory (not executive) powers only. This board had six members, three each from the two leading political parties, appointed by the Legislature from 1889 to 1893 and thereafter by the Governor. Its scope was expanded to include county and township charities. In an effort to attract persons motivated by public service, members were not compensated. Secretaries were drawn from the ranks of asylum medicine. Before 1889, the boards of trustees by law not only appointed the superintendent but also all asylum medical officers

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[178] Hurd, *Institutional Care for the Insane,* 309.
[179] Ibid.

and other employees, "not omitting the scullery maids."[180] This change represented a coup for the medical superintendents and helped to minimize the chances of partisanship interfering with the advisory oversight of the state's asylums.

In the same year, a law was enacted providing for the three new hospitals that were desperately needed to accommodate the population of Indiana. Having expanded to three from an original goal of one new hospital to satisfy state political factions clamoring for the economic advantages of hosting an asylum in their territories, these three included the Northern Hospital at Logansport, the Eastern Hospital near Richmond, and the Southern Hospital at Evansville.

Dr. Smith made it clear that the autonomy of the medical superintendents also gained ground with this legislation: for the first time the medical superintendent was empowered to select and appoint his physician officers and other employees subject only to the confirmation (not approval) of the board of trustees. Yet another glitch arose, however, that had to be worked out. The law inadvertently omitted mention of the power of a medical superintendent to fire his subordinates, implying that only the board of trustees could do so. According to Smith, this much constituted progress, though the board members were elected by the Legislature by the party in power. He observed, "the popular demand for non-partisan control was in the air and growing stronger year by year. The Board of Charities was beginning to exercise influence for good, and the members of the professions and a few of the newspapers were fostering and encouraging the new doctrine."[181]

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[180] Ibid., 309-310.
[181] Ibid., 310-311.

Into this scenario stepped Joseph Rogers in 1883, after serving as medical superintendent at Indianapolis and surviving political and public scrutiny. By this time, the AMSAII was well established and the advisability of appointing an experienced Indiana alienist as a medical engineer to design the three new state insane asylums was not seriously debated. Rogers heeded the call with remarkable creativity and openness to experimenting with three different architectural models for the new asylums. He decided to employ the pavilion plan at Logansport, the cottage plan for the Eastern Indiana Hospital at Easthaven, near Richmond; and the radiate plan, with house-plan features, for the Southern Indiana Hospital at Woodmere, near Evansville.[182] He would then live and work in the administrative building at Longcliff for twenty years, after the first twelve of which he would deliver his mature opinions to the AMSAII members. Rogers knew the business of designing, constructing, and operating insane asylums intimately in every detail from the selection of a site to purpose-built doorknobs and how to manage the expectations of patients' families. He advised his peers in his 1900 speech that in his unquestionably considerable experience, the cottage plan with pavilion features delivered better care to the mentally ill than the Kirkbride plan. Let us follow his experience at Longcliff, the first of the new asylums to be built and opened to help meet the growing demand for benevolent care for the insane in Indiana.

[182] Ibid., 343.

Chapter 4:

Dr. Rogers at Longcliff: Moral Treatment "By Every Adaptable Agency"

Moral treatment practitioners and civic reformers in nineteenth-century American public service expressed benevolence as a character virtue, design principle, duty, and a quality of therapeutic care. Yet if benevolence was the primary ethical principle characterizing moral treatment, medical superintendents also had to accommodate a duty of accountability to the public/state. This duty carried intense pressure to practice thrift in hospital management and accommodate an ever-increasing demand that strained the medical model. As we come now to the historical case of Joseph Rogers[183] at Longcliff Hospital, we will see a nuanced and complex interplay of his benevolent and thrifty practices as expressions of public accountability. How did Rogers cope with the strains posed on benevolent treatment by the primary limiting factors of economy and high numbers of admissions?

This chapter will endeavor to present this historical and bioethical narrative of Dr. Rogers at Longcliff in four parts starting with the man himself, his background and abilities as an engineer, artist, humanist, physician, and public servant; second, how he practiced moral treatment at Longcliff using "every adaptable agency," and how he justified the use of restraints, classification of patients, and other aspects of the operation; third, how he attempted to persuade the

[183] The photograph above shows Rogers c. 1885; courtesy of the author and the Logansport State Hospital Museum, Logansport, Indiana.

hospital overseers and patients' families to cooperate in the practice of moral treatment; and last, his reflections on ethical compromise near the end of his career.

Dr. Joseph Rogers: Renaissance Man

The historical records pertaining to and created by Joseph Goodwin Rogers are voluminous, including hospital records, correspondence, minutes of trustee meetings, reports to trustees and the Governor, articles, a personal diary, and artifacts.[184] Rogers emerges fully and colorfully from the records, an expansive, articulate, and prolifically busy man. He was born in 1841 to a physician father from Kentucky and a gentlewoman mother from Connecticut. During his teenage years in Madison, Indiana, it was not clear that he would have a healthy adulthood. At the age of thirteen, after an injury to his back deteriorated into spinal caries, Rogers spent five years at home in bed. Sometimes assisted by tutors, he studied "the usual college curriculum" of the time, including French and German languages and English literature,[185] and it is likely that his musical activities started then.

Once he recovered and was able to regain physical activities, Rogers travelled and then returned to Madison, Indiana where he spent what appears from his diary to have been a pleasant year. He dabbled in "pleasant scientific chat" at home with visitors,[186] attended scientific lectures,[187] played in the Music Club,[188] played euchre (a card game) with friends,[189]

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[184] Only a fraction of the records could be reviewed in research for this paper. Patient records became available to the public in September 2013, and were not reviewed.
[185] "Notes and Comments," *American Journal of Insanity* (July 1899), 176.
[186] Diary of Joseph G. Rogers, January 28, 1862.
[187] Ibid., February 4, 1862.
[188] Ibid., January 29, February 1, 5, 9, 10, 11, 1861.
[189] Ibid., January 25, 1862.

attended social dances,[190] collected fees (presumably for his father)[191], and studied some law with local lawyers,[192] as he put it, "to please his father," and at age twenty, turned to the study of medicine "to please himself."[193] Graduating in 1864 from Bellevue Hospital Medical College,[194] young Rogers was appointed assistant surgeon to the Union Army, serving in Indiana until the end of the Civil War. He again travelled at the end of the war, this time for two years in Europe where he worked in the clinics of Paris, "with occasional tours into Switzerland, Italy, Germany, Scotland, England, and Ireland."[195] He returned to Madison, Indiana, into general practice in 1864. He served as chair of Therapeutics in the Medical College of Indiana in Indianapolis 1874-76, spending the summer of 1875 in Europe again. Rogers also spent two years assisting Theophilus Parvin, M.D., a prominent obstetrician-gynecologist,[196] in the operation of the *American Practitioner* in Indianapolis. His appointment to the medical superintendentship of the central Indiana mental hospital in 1879 was unexpected, given his experience in general practice, not asylum medicine,[197] although the expansion of the women's department at the Indianapolis hospital during Rogers's tenure suggests that his experience with Parvin's specialization might have helped. Most likely, Rogers was a politically acceptable candidate to both Democrat and Republican factions in power at the time to serve in what could be expected to become a politically-

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[190] Ibid., January 4, 1862: "Enjoyed dancing last night at Major B's to the fullest extent of my desire. We chased away the hours most vigorously, and didn't "rest till morn," as the pleasure loving bard suggests. 5 o'clock had arrived before fatigue triumphed over fun, and tire nature drove us home. Was out this morning "bright & early," however, collecting."

[191] For example, diary entries of January 3 and 4, 1862.

[192] Rogers, Diary, January 8, 1862. Much of the time he spent out collecting fees, which he fastidiously recorded along with expenditures, presumably from his father's patients or from his legal mentors' clients, but he spent some of the time in study. In this entry, he wrote: "Went over to Millton and studied law for half an hour under adverse circumstances, in Squire Abbott's bar room." On February 16, 1862, he wrote, "spent the greater part of the afternoon in humorous, literary, and legal discussions with D—Bright Esquire and others."

[193] Ibid.

[194] State unknown. This could have been in New York, New York.

[195] Rogers, Diary, January 8, 1862.

[196] Obituary of Theophilus Parvin, M.D. *The British Medical Journal* (February 24, 1898), 595.

[197] Ibid.

fraught process of selecting locations, designs, and contractors over several years. He served his first four years in asylum medicine in Indianapolis (1879-1883). In 1883, the Governor appointed Rogers as Medical Engineer to oversee the design and construction of new Indiana hospitals, and he began the phase of his career during which he became an expert on asylum design, construction, and operation.

In 1884, after serving in his new role for some months, Rogers presented to a scientific committee of the AMSAII on "The Therapeutics of Insanity," a paper that offers a snapshot of his thinking in the format of a direct address to his professional peers. He had evidently been asked to cover the *materia medica*—the medicinal treatments in the multi-dimensional regimen provided in asylum medicine. The document is unusual in the Rogers records because of this emphasis; most of his other writing focused on hospital design, construction, and operation. He began as follows to address his colleagues:

> The year past has not been marked by the discovery of any remarkable special methods in the treatment of insanity, nor any very remarkable advance in results. It is true, the usual number of neurotic meteors have shot athwart our special sky and finally found their proper beds; and some good has been found in them after their fires have dimmed; and doubtless, were the exact truth known, there has been some progress made in the world at large in the art of curing mental disease.[198]

This selection bears closer analysis, for it demonstrates the facility with which Rogers communicated in writing (and in person, if the quoted paper was delivered as it was recorded); with forcefulness and nuance, irony, a sense of history, professional propriety, honesty, and creative license. In this instance, he begins with the frank admission that not much has happened in the field of scientific note—a factual assertion likely to engage the trust and credence of his scientist audience. He then describes with a flourish the manic

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[198] Joseph G. Rogers, "Report on the Therapeutics of Insanity," Volume XL *American Journal of Insanity* (January 1884) no. III, 344-352.

patients he and his colleagues share as a natural phenomenon ("neurotic meteors have shot athwart") which inferentially creates a beautiful arc through the abyss of psychosis into their professional care ("and finally found their proper beds"). He seems to both affection and professional distance in this phrasing, appropriate for the paternalistic role of the medical superintendents toward their patients, i.e., as father-figure with a duty to act with authority in the partial absence of the patient's autonomy. He invokes a sense of shared belonging to a unique professional domain ("our special sky"), which perhaps only alienists could understand. Although the choice of phrase, "some good has been found in them after their fires have dimmed," suggests Rogers has condemned the patients to a lack of human goodness during their manic phase, perhaps his point is that the symptoms of illness tragically conceal the goodness of patients; with this statement his audience, as co-legatees of the Enlightenment's compassionate reason, should concur. Noting that there may have been some progress somewhere in the world during the past year reminds the audience of the grand dimensions of their collective scientific endeavors but also acknowledges the profound uncertainty inherent in medical practice ("if the exact truth be known"). Then Rogers brings his introduction to a climax by naming their shared endeavor not as a science but an art.

In using the not uncommon approach of calling a complex undertaking an art, Rogers was not stooping to use a cliché; his choice of words went much deeper. He was a Renaissance man, engaged in musical pursuits and social dancing,[199] well-travelled in Europe, prone to using Latin phrases and quoting Dante. He played the violin, as a young man in a music society that performed locally in southern Indiana, and later at Longcliff, where he strove to bring music and social dancing to the array of activities of weekly life, if not daily

[199] See for example diary entry of January 17, 1872: "Last night danced til 'o'clock on the Prioress.'"

life, for the therapeutic benefit of the patients. He established a hospital orchestra, hired local musicians to play for weekly dances for the patients, and ensured that Christmas festivals included concerts. But bringing the arts into therapy for insanity does not exhaust the ways in which Rogers integrated art and science. His approach to his medical practice, to caring for the insane and depressed and demented, integrated artistic, scientific, and ethical disciplines and principles. His pragmatic approach was to turn "every adaptable agency" to the task of supporting recovery or at least comfort. In a 1883 address at AMSAII on the therapeutics of insanity, he used these words to express his deeply pragmatic approach: speaking of acute mania, he wrote, "the tendency is to *Wear* and *Waste*. The indications are then *Rest* and *Food*, physical, mental and moral, to be secured by every adaptable agency, material and immaterial."[200]

The historical record on Rogers as a physician demonstrates his ethics of benevolence and public accountability as primary; yet it is difficult to disentangle the humanist man from the professional persona, the private man from his public work. He married and had a family of five children (shown in the accompanying photograph, c. 1900),

who lived with him at Longcliff, and the records of his book orders reveals a set of interests outside of work; a letter to a colleague reveals that he and his wife participated in a literary club of some sort, whose activities he supported.[201] He kept and paid for his personal book orders separately from the hospital's

[200] Rogers, "Report on the Therapeutics of Insanity," 344.
[201] Rogers to E.G. Hill, November or December 1897. Letter book A6302, 193. Indiana State Library, Commission on Public Records, Indianapolis. All letters cited belong to this archive.

accounts; an 1897 letter lists a wide variety of reading interests on behalf of himself and his family.[202] As much as he appears to have loved music, literature, and dancing, Rogers seems to have worked to ensure that patients could enjoy the same pleasures at Longcliff, and benefit from them as part of their treatment. The photograph below shows the Longcliff Ball of 1904,[203] possibly limited to staff and medical officers only, but held in the Assembly Hall where patient activities took place. Rogers insisted that the "assembly hall, for amusement, is as necessary as the dispensary, and affords pleasanter if not better medicine. It should be located on the ground floor "for the convenience of the aged and infirm."[204] Even as late as 1925, dancing continued as a popular staple of therapeutic activity at Longcliff.[205] One female patient wrote in 1925:

> I was surprised that the hospital kept up the old custom of dancing. Perhaps I should say it is an old custom ever new. The fox trot was the most modern lesson we had. Then it gives people a chance to play at love, as Mrs. Browning said, "Hamlet dresses love up and acts a play with it."[206]

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[202] Rogers to Montgomery Ward, December 9, 1897. Letter book A6302, 254. The order included the following, some of which were probably gifts for children: Biographies of Musicians (6 volumes), Robert Browning, Hans Brinker magazine, Tanglewood Tales, Wonder Book, Dog of Flanders, From Heine, Cuckoo Clock, Tapestry Room, Mrs. Rorer's Cook Book, Horace Walpole, Taine's English Literature (2 volumes), Adventures of two Dutch Dolls and Gooliwog, Cambridge Poets, Shelly, Gabriel Dante Rosetti, Handy Volume Classics: Abby Constantine, Vicar of Wakefield, Lucille, Cranford, The Princess & Maud, Favorite Poems, Longfellow's Poems, and McClure's magazine for one year.
[203] Photograph courtesy of the author and the Logansport State Hospital Museum, Logansport, Indiana.
[204] Rogers, "A Century of Hospital Building for Insane," 7.
[205] Samuel Dodds, *Work-and-Play Treatment (Occupational Therapy) at Longcliff (Logansport State Hospital)* (Indianapolis: Burford, 1925), 18-46.
[206] Ibid., 19. Unnamed patient.

By "old custom" she meant the quadrille, a dance from Rogers's youth.[207]

Pragmatically and self-consciously virtuous, ever mindful of the effect of his actions and image on the public's perception of his profession, Rogers strove to secure the tangible and intangible components of therapy as a kind of array from which to choose a combination as a treatment plan for an individual patient. It was, to Rogers, as important to have the right variety of components available for adaptation to the therapeutic needs of the patient as it was to have the right musicians and instruments playing in an orchestra to play a composition to full effect. The following excerpt from a 1897 letter neatly illustrates his constant pragmatic efforts to secure the components of a fully operative array of therapeutic agencies including musical ones. Rogers wrote to a young man who had written in search of a job as an asylum attendant, returning the letters of reference and seizing the opportunity to recruit for the hospital orchestra:

> I regret to have to state that it is contrary to the policy of the institution to employ married men as attendants, and I therefore can offer you no encouragement at the present time. I am quite desirous to secure a good clarinetist who is a single

[207] Ibid., 19.

> man of good size who may serve as an attendant. Perhaps you can put me in communication with someone.[208]

Even if Rogers wanted to have a hospital orchestra in part to satisfy his own desire to participate in making music, he must have believed that the practice of musical play, and for others the pleasure of listening to it, included some experiential dimension that contributed to the strengthening of human mental and emotional health. Perhaps early in his career, he may have posited this theory based on examining the healthful effects on himself of playing violin in a group setting and listening to music. But later in his career, as in 1897, he was still almost frantically recruiting for a versatile clarinetist-attendant to fill a spot in the hospital orchestra, suggesting that although this particular agency had demonstrated a benefit to the hospital population, neither hiring practices nor the regular budget was adequately supporting it.

There is a parallel in any musical composition or social group dance to a system of different parts acting in concert to achieve something as a whole. In an orchestral piece, at different times one instrument is allowed to dominate while others are silent or softer; tempos and rhythms can be played with to achieve a desired impression or effect. So too did Rogers, as a hospital director, strive to use the hospital itself, the landscape and grounds, order and recreation, food, *material medica*, hygiene, exercise, routine, sleep, the agency of human relations, and other activities of living into a varied but balanced whole for each patient.

Perhaps nothing illustrates Rogers's combination of engineering pragmatism as a problem-solver with his benevolence ethics as a doctor and love of arts better than the Rogers Asylum Knob, which he designed and ordered from the Yale & Towne

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[208] Rogers to an unnamed man in Detroit, Michigan, December 6, 1897. Letter book A6302, Page 243.

Manufacturing Co. of Chicago and New York for the construction of the three new Indiana hospitals. The following photograph shows two doorknobs from the original Longcliff hospital that may be specimens of the Rogers Asylum Knob, although this conclusion has not yet been substantiated. As Rogers described the knob he designed, it was "dead," not intended to turn or engage a lock, and requiring a special screw driver to remove, which presumably he would not make available to patients.[209] Thus we can infer that their only purposes were to solve an engineering problem: to enable a person to maneuver a door without being subject to removal and possible use in a destructive manner. Yet it would have been characteristic for Rogers to make such a practical device ornamental, because he believed that beauty could provide comfort to the distressed and stimulating hope to the depressed.[210] The use of decorative doorknobs might seem especially right to Rogers if they were used on the open-paneled doors he used in the wards to enable attendants to observe the patients. The touch of beauty might compensate a bit for the loss of privacy; and if this could be done economically—as he argued it could—Rogers believed the public would support it.

Securing adaptable agencies was not always as easy as designing and installing the Rogers Asylum Knob. It required continuous efforts and the cooperation of state overseers and patients' families in addition to hospital staff. Rogers led these efforts with remarkable energy, creativity, discipline and frugality. When the doors opened in July 1888, Longcliff was far from complete, but it was the first of the three new asylums to be sufficiently ready

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[209] Rogers to Dr. William M. Edward, Superintendent of the Michigan Asylum for Insane, February 17, 1898; Volume A6302, 465.

[210] Photograph courtesy of the Museum, Logansport State Hospital, taken by the author in February 2013.

to admit patients. Rogers worked continuously to fulfill his vision of what Longcliff as a proper insane asylum for the provision of moral treatment should be. This work required that he first complete the site's basic engineering and other structural characteristics, while incrementally striving to enhance both interiors and the grounds for the benefit of the patients and staff, without exceeding the fiscal constraints of the State of Indiana and its governing bodies. Some of the first issues were quite fundamental, demonstrating that it was no easy task to implement Kirkbride's engineering basic standards: ensuring adequate heat, insulation, water supply and filtration to avoid the prolonged need for manual hauling and to minimize the incidence of diarrhea amongst the patients and staff. Although he had served as the superintendent of the Indianapolis asylum, the realities of building and operating a new asylum from scratch proved to be a formidable challenge even to a man of his equally formidable abilities.

The ultimate means for securing adaptable agencies that could not be obtained from the existing budget (which covered everything from butter to horseshoes[211]) or from the hospital land (as could milk from hospital cows, food grown in the gardens, and chickens born to the asylum farm[212]) or from the efforts of staff and patients (such as shoe repair by a patient,[213] specialty rosebushes donated by another Indiana medical superintendent,[214] and labor around the hospital gardens and grounds[215]) lay in making formal requests to the Board of Trustees for appropriations for specific purposes. The reports from Dr. Rogers to the

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[211] See for example,1898 Report of the Medical Superintendent, Appendix, 57, 59. Indiana State Library, Commission on Public Records, Indianapolis. All reports from Rogers to the Board and from the Board and Rogers to the Governor belong to this archive.
[212] Ibid., 74.
[213] A shoe shop was set up under the supervision of the head attendant. Rogers reported that the work of shoe repair "is being very neatly and well done by John Claus, a chronic patient." Report of February 1889.
[214] Rogers to S.E. Smith, December 3, 1897, Letter book A6302, 238. "Your offer of crimson ramblers and Marechal Niel roses in the spring will also be gratefully remembered."
[215] For example, in November 1888, Rogers reported that all employes not otherwise occupied had been helping to prepare for winter. Report of November 1888.

trustees and governor include numerous such requests, which bear scrutiny for clues about his persuasive strategies, the role his ethics played, and which battles he considered worth the fight.

When common sense and health/medical arguments would suffice, Rogers used them, and when one request did not succeed, he would repeat it, usually with success. The problem of the untherapeutic effect of certain smells is a good example. In November 1890 and almost a year later, in the exact same words, he reported to the Board:

> The Sauer Kraut, pickles, onions, potatoes etc. kept in the Rear Center cellars unavoidably fill the bed rooms of the east wing with very disagreeable odors and certainly don't add to the healthfulness of that house.

He asked for authorization to build a new structure for storing the smelly vegetables away from the bedrooms.[216] After the second request, the Board acceded.

A far more serious health concern lay in the inadequate water supply. Dysentery and malaria afflicted the hospital population several times before the state provided enough financial support to lay the proper water piping, dig a new well for a pure supply, and eliminate areas of standing water and the disruptions caused by excavations. Rogers employed the obvious argument that the hospital should promote health and dispel disease, and supplemented this by reporting on the higher rate of staff resignations during the months of illness, and by demonstrating the extreme thriftiness of his operation. Along with the monthly reports of admissions, discharges, deaths, hirings, firings, promotions, improvements, and expenditures, Rogers reported on revenues generated from the sale of surplus food grown at the asylum farm, some maintenance fees by patients who could afford it, and costs saved by employing staff and patients in some projects. Finally, at the end of

[216] The reports of November 1890 and October 1891 used identical language.

many reports, he adds: "Sales: old bones, lbs of rags, lbs of iron and lbs of paper."[217] By demonstrating the great lengths to which he went to make the hospital self-sufficient and economical, Rogers elevated the moral standing of his requests for further investment in reasonable expenditures that would promote the health and well-being of the entire population. Thrift was clearly a virtue in a public benevolent institution and helped to justify further expenses.

In other cases, the specter of public embarrassment, especially driven by the newspapers, resulting from a failure of the hospital's duty of care to the patients, when woven into a report from Rogers, did the trick in persuading the Board to authorize a new expenditure for an improvement. He wrote the Board in July 1891 urging authorization to build a detached mortuary for the temporary storage of human corpses and most-mortem examinations, "desirous for obvious scientific reasons."[218] He explained that while most patients' remains were kept in a room on the ward to which they belonged until claimed by friends or buried in the hospital cemetery, occasionally a corpse was better kept in the basement of the Rear Center building. Rogers then reported on the demise of the corpse of Ira Ewing, who had died from kidney disease with extensive fistulae in ano.

> This morning when a representative of the family called with an Undertaker to remove the remains the Supervisor made the distressing discovery that during the night at some time a rat or cat, probably the former, had burrowed under the door frame, gotten into the room and completely excavated both eye-balls.[219]

Somehow a *Wabash Times* newspaperman was given a statement of these facts. Rogers noted with concern that the journalist might "publish the details given above in a manner not at all just or to the credit of the institution." He blamed himself for not raising

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[217] See, for example, reports of May, June, and August 1890.
[218] Report of July 1891.
[219] Ibid.

the issue of a mortuary earlier and explained that these basement arrangements had sufficed before without mishap. He added that he had asked the undertaker to visit the editors of the Logansport newspapers "with a view to informing them in a just and proper manner of the facts in the case."[220] Within two months, a mortuary was under construction.[221]

Support from the state for recreational (including artistic and religious) activities appears to have been modest; Rogers had to make frequent requests to support them and apparently relied on private donations from patients' friends and families, friends of the institution, and local vendors to provide special meals, gifts, and entertainment at holidays, especially at Christmas. When an initial voluntary system of local churches providing clergy for Sunday services petered out, in November 1889, Rogers asked the Board for funds to pay clergy an honorarium. At the same time he requested authorization to pay local musicians to play at weekly dances for patients, arguing that the Sunday afternoon services offered "in the Assembly room for the benefit of the inmates, officers, employes, and neighbors" were "generally highly appreciated" and after one year the volunteer system "fallen into disuse and a very beneficial break in the monotony of hospital life is no longer enjoyed."[222] Appealing to state pride and competitiveness in keeping up a scientifically with other states, Rogers argued further that state financial constraints were putting Indiana behind peer hospitals: as "a matter of economy, the dances given to patients in similar institutions at short intervals have not had a very prominent place in the curriculum here. These entertainments are universally considered to be an important feature in the moral treatment of the insane and in this general opinion I myself join." Rogers envisioned weekly dances in which each patient danced with an employee, officer, or visitor, "carefully

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[220] Ibid.
[221] Report of September 1891.
[222] Report of November 1889.

supervised by the attendants and medical officers."[223] Since the request does not appear again within several years of reports, the Board evidently agreed.

The lists of needs went on and on. There weren't enough chairs to go around at the Administrative Building,[224] not enough rocking chairs for the men's ward,[225] nor were there enough water closets and baths on the third floor where the officers lived,[226] nor in the laundry building. In the case of the laundry building, the necessity of an attendant escorting a patient to the water-closet resulted in her having the opportunity to elope, an event which furnished Rogers with an effective argument to the Board to fund more water-closets.[227] The original iron pots purchased for the general kitchen turned hominy and rice black—presumably demoralizing for anyone to eat—so Rogers requested authority to buy new copper ones.[228] Somehow, the furnishing of clocks and a supply of rocking chairs for the men's ward were overlooked at the beginning, and Rogers had to request these specifically.[229, 230] Framed art for the walls of the patients' wards and common spaces was not part of the budget, and had to be solicited or received from charitable donors, whom Rogers fastidiously thanked and acknowledged in both reports and correspondence.

> "Through the activity of the Assistant Physicians a very considerable number of pictures have been added to the number sent us by Mr. Klackner last spring; these have been mounted and framed and now adorn the wards and reception rooms of the Hospital. The expense attached will be repaid many fold in the cheerfulness added to the heretofore blank walls."[231]

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[223] Ibid.
[224] Ibid.
[225] Report of February 1891.
[226] Report of November 1889.
[227] Report of January 1890.
[228] Report of November 1888.
[229] Report of October 1891.
[230] Report of February 1891.
[231] Report of January 1891.

Winter's cold called for battening of the ceilings under the rooves to hold the heat in, labor provided by staff and patients, but materials requiring Board authority to be purchased.[232] No therapeutic agency could be provided to patients without some effort by the state, the staff, the Board, or Rogers himself. Every request had to be framed persuasively.

Another adaptable agency came in the form of families and friends of patients, who offered the comforts of home and visits to varying extents. The state furnished basic needs such as beds, pillows, bed clothes, clothing, food, medical care (including care for intercurrent illnesses), recreation, transportation, etc. But many patients were able to enjoy the supplemental help of families and friends in the form of little comforts of home: a chair, a rug, a dress, some apples, some wine. Rogers acknowledged these provisions personally by letter and usually commented on the way in which the individual patient would benefit from the item.

To every letter of inquiry from a next friend or family member about a patient, Rogers replied personally, often on the same day of receipt or shortly thereafter. The state archives provide a rich historical record of this correspondence, at least of Rogers' side of the epistolary dialogues with family members. In this correspondence, his commitment to public accountability and his willingness to engage cooperation from families in care under his direction, that is, of himself to the public and of the public to the patient, is abundantly evident. In examining samples of his letters to family members in response to their inquiries, we can see the complexity of his pragmatism in fulfilling the benevolent duties of his office. In this aspect, Rogers's letters shed light on the interdependency of public accountability as a principled form of action and benevolence as another form of principled

[232] Reports of August 1889 and February 1890.

action, as a duty, and as a character virtue, not only for hospital employees, but for patients' families.

Rogers understood that letters to patients could either support or impede a patient's progress, depending on the content, tone, and relationship with the writer of the letter, and the patient's emotional state. He oversaw and managed the flow of correspondence to and from patients, withholding some letters to or from some patients in his discretion, and apparently confident in his judgments based on experience. For example, he wrote to Mr. G.A. Smith of South Bend, October 27, 1891, "She has written a great many letters but I think it best to send only those which she writes to you, for the reason that their contents are such that I don't think you desired them sent, being often silly, incoherent and unreasonable."[233] Some families, like the wife of Jacob Miller of Turkey Creek, expressed confusion and disappointment in the correspondence they received from Longcliff. Mrs. Sarah Miller apparently wrote to Rogers asking why neither husband nor doctor had written to her. Rogers replied in a manner that reveals his canny knack of clarifying mutual obligations, disabusing others of misconceptions, justifying the hospital's actions or omissions, and communicating the often poor status of a patient in a straightforward factual manner that at times delivers a rebuke or reprimand, either directly or indirectly:

> You ask why we do not write to you. Yours of a former date was fully answered on the 6th addressed to you at Turkey Creek through your attorney…In your letter of the 11th you give no address whatever, which please do not omit in the future.
>
> Mr. Miller is improving somewhat. He eats well, sleeps well and is looking in good physical condition. He at times asks about home and if I have heard anything from the boys and asked this morning if they were done threshing. I advised him to write home but he was not inclined to do so. Stationery is furnished here and he can write any time he desires. His improvement so far is fairly satisfactory, but time will be required to determine the ultimate outcome of his case.[234]

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[233] Rogers to G. A. Smith, October 27, 1891, Letter book A6302, 72.
[234] Rogers to Sarah E. Miller, October 16, 1891, Letter Book A6302, 14.

Mr. Miller is not writing, then, because he doesn't feel like it; he has asked about the farm and his sons although not necessarily about his wife. Mrs. Miller can infer that given his modest progress to date, she will need to adjust her expectations if she is to get along with Dr. Rogers, the gatekeeper to her husband.

Rogers was at his frankest in his reply to Mr. L.A. Dawes of South Wabash, who wrote about his wife:

> Do not get impatient, it takes time for letters to come and for letters to go. If you wish immediate responses use the telegraph and we will answer in the same manner at your expense…Your letter was promptly given her but she does not appear mentally competent to answer it, at any rate she has not done so. The statement in your card that she has not been permitted to answer it is totally unwarranted. I very much fear, my dear sir, that you are in a more unhappy state than she is, and in as much as we are endeavoring to benefit your wife in every way possible, I desire to urge that you do not find fault where there is none.[235]

Thus it would seem, Mr. Dawes could conclude, that family members of patients should demonstrate character virtues too—not only benevolence toward the patient but patience toward and trust in the medical superintendent. Luxuries like a telegram exceed the public budget, and where that ends your duty to pay for your own impatience begins. All of this Rogers conveyed politely but clearly. He also included a paragraph detailing in lay terms Mrs. Dawes's clinical status; the medical man's ability to report precisely from the distant hospital campus could only strengthen his aura of authority. It also demonstrated Rogers' strong sense of duty to report to the family. He met families half-way, demonstrating his own part and clarifying what theirs should be in the effort to support the patient's recovery or well-being.

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[235] Rogers to L.A. Dawes, November 2, 1891, Letter Book A6302, 97.

If Rogers comes across as sharp in his frankness toward families, it is reasonable to interpret this style as expressing his conviction that honesty with patients was indispensable to maintaining trust in the therapeutic relationship. He exhorted families to practice this honesty toward their relatives in his care. In this vein, Rogers wrote to Mr. William Molter of Kentland:

> Your recent note at hand. Mrs. Roy, since her return to the hospital has been getting along very well although at times a little emotional. However, she is overcoming this tendency. She continues to think that she was brought back under false pretenses with a promise that she would go to see her cousin. You state in the letter you sent her that "We will come and get you before long." Inasmuch as I suppose you have no intention whatever of doing that and it being contrary to our rules to deceive people, I will take the liberty of not handing her the note you sent.
>
> Please remember this once for all, - do not under any circumstances make statements to her that you cannot or do not intend to fulfill.[236]

To an inquiry from Miss Anne Jessup of Burdick, Rogers replied with a report on her sister, suggesting that the patient "might I think appreciate a letter from you" and that "she still wears with pleasure the dress you left for her" after a personal visit. In this case the patient had often requested a transfer to another less crowded ward, which request Rogers reported having fulfilled, to the patient's satisfaction. This letter illustrates well how Rogers understood the importance of customizing moral treatment to the individual needs of a patient, as well as his grasp of the transformative power of a special dress (another adaptable agency of care) on a patient's mood or self-esteem.[237] To Mr. W.H. Warner of North Webster Rogers wrote of the wife, "I think that the dress ordered for her sometime ago will be a benefit to her; garbed in that I think she will feel more like appearing at the entertainments which are frequently held for the benefit of the patients."[238] This patient also

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[236] Rogers to William Molter, November 22, 1894. Letter book A6302, 375.
[237] Rogers to Anne Jessup, October 17, 1891, Letter book A6302, 24.
[238] Rogers to W. H. Warner, October 21, 1891, Letter book A6302, 44.

benefitted from a chair, rug, and "especially the cushion" sent by her husband to the hospital.[239]

Not all families were so attentive even in response to requests from Rogers to send specific items of clothing (e.g., "3 gowns, 1 worsted dress, new, for best").[240] Occasionally he had to make extra efforts to advocate for a patient to her family, as he did in writing to Benjamin Flemming, who had resisted such a request for new footwear for his wife.

> The shoes are necessary in order that she may be out doors and take exercise, the slippers she can only wear in the house. The shoes last sent are completely worn out – you know her careless habits about her clothing, it required a great deal of washing attention…Whenever you get a clothing order from here you may be assured that it is needed.[241]

Rogers not only argues forcefully from the stance of the simple reasonableness of the request but also manages to convey his intimate familiarity with the individual patient, among the 300 to 400 patients in residence at the time. He invokes the shared knowledge of the patient – "you know her careless habits"—to garner the trust and confidence of the patient's husband and encourage the latter to join him in caring for her according to his direction.

In another letter, Rogers replies to a woman who apparently inquired if her husband could come home by setting her expectations realistically and conveying his own duty to keep them advised of the patient's status. He wrote to Mrs. T.W. Butterworh of LaPorte:

> Mr. Butterworth's physical condition at this time is very fair—better than it was when he came. He usually eats pretty well now and sleeps enough. He seems very anxious for letters and papers from home and frequently asks if there is mail for him, or if he is going home 'today.' I will advise you should it at any time seem best for him to go home.[242]

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[239] Ibid.
[240] Rogers to an unnamed man, October 17, 1891, Letter book A6302, 23.
[241] Rogers to Benjamin Flemming, November 4, 1891, Letter book A6302, 108.
[242] Rogers to Mrs. T.W. Butterworth, October 22, 1891, Letter book A6302, 49.

The Ethical Use of Classification

Like Thomas Kirkbride, Joseph Rogers advocated the use of, and practiced it at Longcliff, classification of patients by clinical status, which included physical, mental, and social characteristics. Scientific observation supported this model: patients seemed to do worse when living primarily with others who are in worse condition than themselves, and conversely, tended to do better when living primarily with others who are living in a similar state of mental health and exhibit similar social habits with respect to dress, hygiene, and conversation.[243] Thus the broad ethical underpinnings of classification of patients could be said to lie in benevolence, but it also aligned well with the thrift of housing patients together in shared dormitories.

The design and construction of Longcliff Hospital expressed and reinforced the classification of patients. Blocks or pavilions housed residential quarters (wards) for patients and staff attending them (the assistant medical officers lived in the Administrative Building), with the most noisy and violent patients located the farthest from the central Administrative Building. In this way, the block/pavilion plan resembled the common assignment of the noisiest, dirtiest, and most violent classes of patients in the "back wards" of the Kirkbride/linear-planned hospitals. While the practice could be seen as punitive and could be conducive to neglect and abuse by having such patients farther from the view and hearing of visitors coming to the Administrative building, the original rationale was practical and benevolent: to minimize the disturbance to the healthier patients.

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[243] Kirkbride, *Hospitals for the Insane,* 58.

Rogers considered the following classifications essential, one for each sex: the quiet and infirm, the quiet workers, the quiet and convalescent, the suicidal, the epileptic, the noisy and violent.[244, 245]

> As to the general plan, it may be reasonably said that the best one is that which comes nearest to combining the merits of all systems, and by which may be secured the best adaptation of means and methods for the best care of each special class, giving to such as require it close and incessant supervision and control, in quarters adapted to them; to others the skillful and soothing care of the physician and nurse, in cheery infirmary rooms; to others the largest liberty to exercise their bents, usefully if possible, with no bars but those of moral force; to others the quickening spur of cheerful and amusing excitement; and to all, something as near like a home as circumstances may allow.[246]

In spite of his pragmatic support of classification-based housing assignments for patients, Rogers believed a patient's assignment to a class should not be considered permanent; both his ethics of benevolence and his frank appreciation for the uncertainties and limitations of scientific knowledge led him to passionately oppose the labelling of any patient as "incurable." One of the greatest issues to vex Rogers and his peers and yet to elicit the most pointed ethical response was the tendency of a large proportion of patients not to recover—the "chronic class." From the very first month, Rogers had to fight the influx of chronic cases to reserve space for those patients who might benefit from the classic moral treatment model.

The original Rules for Admission stated that patients "shall be preferred" in the following order of priority: first, acutely insane patients, initial or recurrent; second, chronically insane patients who are dangers to themselves or others; third, chronically insane and harmless patients who need special medical and custodial care on account of mental disease; and finally, the chronically insane who were harmless and needed only special

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[244] Rogers, "A Century of Hospital Building for Insane," 6-7.
[245] Logansport State Hospital, Hospital-Community Relations Committee, 1988, 7.
[246] Rogers, "A Century of Hospital Building for Insane," 6.

custodial care.[247] The county commissioners across Indiana, however, proved too eager to offload their chronically ill inmates to cooperate with this order of priority. Rogers wrote to the Board in the first monthly report after the opening of Longcliff, when 133 patients of the intended total of approximately 300 had been admitted:

> "I regret to say that, notwithstanding the proclamation of the Governor which was sent to every County Clerk and widely published throughout the State by the daily press, the impression has continued to prevail that this and the other new Institutions were intended solely for so called incurable cases, and as a result of this applications have been almost invariably for the benefit of the chronic class; more particularly on the part of County Commissioners desiring to remove insane persons from the poor houses. A few recent [onset] cases have been received from adjoining Counties; these I am pleased to state have all done well in Hospital and without exception give fair promise of recovery within a reasonable time, and I am satisfied, after a months [sic] experience, that the Institution presents unusual advantages for this class of patients.[248]

And from the start, Rogers had to rationalize providing the same care to all patients, regardless of the low likelihood of recovery for some. In his August 1888 report to the Board, he wrote, "if there is for a while to be no brilliant record in the matter of cures, every effort will be made to conserve the not very vigorous lives of those that we have in charge and in that way possibly do something for the reputation of the Institution."[249] In this quandary Rogers echoed Kirkbride: "When patients cannot be cured, they should still be considered under treatment, as long as life lasts; if not with the hope of restoring them to health, to do what is next in importance, to promote their comfort and happiness, and to keep them from sinking still lower in the scale of humanity."[250]

In spite of the immediate application for admission by chronically ill and infirm patients, as discussed above, Rogers did not apparently foresee the need for a furnished

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[247] Hurd, *Institutional Care for the Insane*, 351.
[248] Report of August 1888.
[249] Ibid.
[250] Kirkbride, *Hospitals for the Insane,* 59.

space to accommodate occasional visits from patients' family and friends,[251] suggesting that in spite of prevailing trends nationally of asylums being filled with the chronically ill, Rogers had expectations for relatively quick recoveries (from weeks to months as opposed to years). He generally allowed visits to patients only if he judged them to be beneficial to a patient; visits were prohibited on Sundays so that patients and staff could attend religious services and observe a day of rest,[252] all of which was therapeutically valuable. In 1890, he petitioned the Trustees to allocate funds to adapt or construct a sitting room for this purpose.

Rogers expressed his most passionate opinion on the subject of the absolute duty, in his mind, of never labelling a patient or class of patients as "incurable." Even if the probability of improvement or recovery was nil, Rogers believed that it was devastating to give in to such a temptation. He wrote to a patient's relative, Mrs. L. J. Starret of Marion:

> There are no wards in this hospital devoted to the incurable, and the word incurable is not applied to any class of inmates. Should such arrangements be made we might as well place Dante's motto over the door: "He who enters here leaves all hope behind," and this you certainly understand would not be wise. I have told Mr. Purcell my views in regard to his case. I did not tell him he was placed among the incurables; he is in error there. What I did say was, that his personal habits were such that it was necessary to remove him from the front ward which he had occupied to another on account of the tendency named, that is, the disposition to be careless in his personal habits.[253]

The reference to Dante's motto is to "the Inferno" by Dante Alighieri (1265-1321), in which the narrator says, "Such characters, in color dim, I mark'd/Over a portal's lofty arch inscribed." The full text would have been a lot for a craftsman to inscribe, but the key lines for Rogers's purposes could be these: "Through me [the gate to Hell] you pass into the

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[251] Report of December 1890.
[252] Rogers to Harvey Kimes, October 21, 1891, Letter book A6302, 41.
[253] Rogers to Mrs. L. J. Starret, November 21, 1894, Letter book A6302, 155.

city of woe;/Through me you pass into eternal pain;/Through me among the people lost for aye…All hope abandon, ye who enter here."[254]

For Rogers, to whom sensory perception of the environment carried either therapeutic or destructive effect on a patient's mind and heart, the label "incurable" spoken was as destructive to a patient's mental health as confronting a sign over the asylum gate welcoming him to an eternity in Hell. Given Rogers's faith in the agency of purposefully-designed buildings, we can reasonably entertain the idea that he meant in a literal and scientific sense that putting such a motto over the asylum door could be predicted to deter recoveries. This statement attests conversely to his faith in the hope-inspiring power of a pleasant, cheerful, supportively designed environment.

Dante's motto carries another layer of meaning in Rogers's usage. If the hospital is the equivalent of Hell, then the moral status of the patients would be the same as that of sinners, i.e., persons whose own actions caused the punishment they receive. Such a notion went against the moral treatment movement's concept of the patient as innocent, her disease as an unfortunate condition and not a divine punishment, with a moral status of a person with limited autonomy who needs protection and assistance. We cannot know if Mrs. L. J. Starret of Marion understood these nuances in the letter she received, but it seems likely that Dr. Rogers's point came through clearly: that Dr. Rogers would never give up hope on Mr. Purcell, and this message could very well have given her some comfort.

As the pragmatist, Rogers devoted his operations to promote comfort at whatever level of health a patient could reach. For many men with chronic, non-violent illness, working on the hospital farm presented the best possible solution of a productive, supported

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[254] Dante Alighieri, *The Divine Comedy* (The Harvard Classics 1909-1914), "The Inferno," Canto III, lines 1-3, 9. http://www.bartleby.com/20/103.html, accessed October 10, 2014.

life under medical care. Indiana was a farming state and many of the patients came from farming families or jobs, so for these patients, activities and rhythms of daily, weekly, and seasonal life closely resembled those at home. Rogers hired a farm manager who with his wife supervised the activities of these patients.[255] The labor of patients on the farm helped to reduce food costs to the state. Longcliff was not completely self-sufficient in growing its own food, but Rogers reported dutifully on each crop's outcome and justified any purchases from outside the hospital farm. Below is an example of his summaries:

> Beans and cucumbers have been pickled and stored. Sauerkraut is now being made. Large crop of mangel wurtzels will be stored. Parsnips, carrots, salsify and table beets, winter cabbage. Turnips destroyed by grasshoppers, corn crop small and poor in quality. Some good potatoes but may have to buy some.[256]

This level of detailed accounting, sustained over his tenure as Medical Superintendent, carried a force of its own in demonstrating creativity, hard work, and thrift, the virtuous management of public funds. Rogers had a close personal relationship with the state's financial unreliability; in 1889, Rogers used his own personal funds to tide the payroll over at Longcliff while the state legislature resolved its budgetary impasse.[257] By 1898 in his biennial report to the Governor, Rogers was sounding frankly irritated with the state's lackluster financial supply given the increasing demand: "Since the beginning Indiana has failed to meet this growing need in a persistent, progressive manner."[258] Calculating the current prevalence of insanity among Hoosiers as 1 in 675, he laid out his charge, condemning the state for perverting the moral treatment model:

> When there is kept ready a hospital place for one in every 675 of her citizens…then will the thought work of the alienist cease to be largely a mathematical problem as to how many can be crowded into a given floor space and make room

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[255] Hurd, *Institutional Care for the Insane,* 355-356.
[256] Report of October 1891.
[257] Indiana Historical Bureau, *Indiana Historical Bulletin* (Indianapolis, June 1963), 88-89.
[258] Report to the Governor (Indianapolis, 1898), 22.

> for something better and wider and higher, the individual and collective betterment in every way of all who are sick in mind and body also.[259]

The Ethical Use of Restraints

At the other end of the spectrum of agencies from recreational activities, and only as a last resort, Rogers was willing to employ physical restraints to prevent patients from harming themselves or others. His pragmatic benevolence on this issue was also aligned with his duty of accountability to the public: he had to report to the Board every incident of the use of restraints with an explanation. In his 1898 report to the Governor, Rogers rationalized the use of restraints:

> [A]t Longcliff, the largest liberty, compatible with the various tendencies and degrees of responsibility, is not only allowed but fostered. …personal, mechanical restraint is used only when absolutely needful on account of tendency to violence and destructiveness, and only on order of a physician, a record being kept thereof…[260]

Individual restraint filled a place where other, telescoping and overlapping methods of surveillance and containment did not succeed in preventing self-destruction or violence towards others:

> Outer doors are kept locked; small bed room doors, all having open panels to facilitate observation, are locked at night; the windows of small rooms are covered by steel wire guards; other ward windows are blocked so as to be opened only a few inches, above and below.[261]

Rogers acknowledged the tendency of the public to equate the asylum with a prison, and admitted the limitations on personal liberty, but argued by comparing it to asylums of the eighteenth century, claiming scientific evidence of the success of moral treatment, and

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[259] Ibid.
[260] Report to the Governor (Indianapolis, 1898), 15.
[261] Ibid.

insisting that Longcliff was like all other contemporary mental hospitals: "the institution for the insane of the present day has come at length to be a hospital in which to minister to minds diseased; it long ago ceased to be a jail."[262]

> A hundred years ago institutions for the insane were built like prisons, a strong cell for every inmate, shackles on many, massive bolts and bars everywhere and a high wall encompassing all, with a single sally port guarded day and night…Under the impelling influence of humane sentiment a radical change has been gradually wrought since then in the ways and means of caring for the insane, and experience has practically justified it, showing, as it has, that whatever adds to the mental, moral or physical comfort of the patient tends to cure, where cure is possible.

Rogers also explained the use of restraints in letters to family members, of which his letter to Mrs. Kalmbacher of Ilion about her son provides a good example of Rogers' minimum-necessary approach to the use of restraints, in this case to promote rest and possibly to prevent disrobing and masturbation, and not for punishment:

> …[Y]our son has improved in some particulars the last week. At present it is necessary to restrain him at night only and during the day he wears his clothing well and his behavior is fairly good. While he does not converse coherently and rationally, he is not so profane and obscene in his talk as formerly. His appetite is excellent and he is in good physical condition. We hope the improvement now commenced will continue.[263]

In a letter to Mrs. P. A. Ekdal of Hagman about her sister, Rogers explains the non-use of restraints where it might otherwise be considered appropriate:

> She is not at all troublesome to care for excepting at times she manifests a disposition to strike herself on her cheeks with her hand very suddenly and without any premonition. I have never thought it desirable to restrain her in any way because this only happens occasionally and the bruises which she inflicts upon herself are not serious.[264]

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[262] Ibid, 14.
[263] Rogers to Mrs. Kalmbacher, November 2, 1891. Letter book A6302, 103.
[264] Rogers to Mrs. P.A. Ekdal, October 28, 1891. Box A6302, 87.

It appears that occasionally a severely violent patient would be transferred to Indianapolis, suggesting that within the state system, the capital's asylum might still serve a more specialized use with its back wards, and allowing Longcliff to remove patients who threatened the medical staff to an extreme degree. Mr. H was so transferred in April 1891 for "his violent and vicious attacks upon the medical officers…under the delusion that we were the prime factors in all his misfortunes and in bringing him here with the intention of poisoning him."[265] Strong walls and locked doors still found their uses where the severity of disease overcame moral methods.

1900: Reflections on Ethical Compromise

His two decades as an alienist provided intimate and extensive experience in medical engineering and moral treatment, experience which shaped Joseph Rogers's opinions and served as the basis for the high point of his career: an address he delivered as President of AMSAII in 1900, entitled "A Century of Hospital Building for the Insane."[266] His career in asylum medicine had spanned nearly 50 years beyond the publication of Kirkbride's 1854 masterwork, during which era of population explosion Rogers had faced the challenges of adapting moral treatment to hospital populations some four to six times the original ideal size contemplated by the AMSAII standards. He admitted to compromise; his entire career in asylum medicine could be described as intimately familiar with the pragmatic struggles of realizing benevolence in public care for the mentally ill. At this time, Rogers cited 120,000 insane people in the U.S., more than 150 hospitals, more than 15,000 attendants and nurses;

[265] Report of May 1891.
[266] Rogers, "A Century of Hospital Building for the Insane," 1-19.

and 20 to 40% recoveries of those admitted annually.[267] The population of Longcliff was around 1,000, three times its original size.

In this speech, with a sense of resignation, Rogers describes the ethical conflict that shaped the arc of the moral treatment movement: an economizing state pressuring medical superintendents to maximize occupancy and minimize cost; to which challenge benevolence resisted, calling for maximizing the comfort and care of the patient and chances of recovery and to provide the most compassionate affordable custody of those who did not recover. He had not given up on moral treatment; he had merely found the state lacking in support.

Rogers tends to distinguish subtly between the State and the public. "When the State pays…cost often limits the embodiment of the ideal; custom and routine too often antagonize the best laid schemes, and popular prejudice, based on ignorance and neglect, can be cleared away from the path of improvement only by a slow and laborious enlightenment."[268] He echoes Dorothea Dix in complimenting the public for its compassion: "Fortunately, the heart of the people is not hard, and when a need is felt and fully understood, promising methods are usually approved and means are provided with a free hand."[269] The compassion of the people will, in Rogers's view, eventually compensate for the meanness that the State's utilitarianism produces, and right the balance toward benevolence. As he said with respect to insane hospital architecture in 1900: "[It] should be plain, but not meanly so. The State, or rather, the public, which pays, does not expect it and will severely criticize, if it be so."[270]

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[267] Proceedings of the American Medico-Psychological Association, July 1900, 146-147.
[268] Rogers, "A Century of Hospital Building for the Insane," 2.
[269] Ibid., 2-3.
[270] Ibid., 6.

For all his many points of agreement with Thomas Kirkbride, Rogers stated his opinion to AMSAII that the linear plan was not the best. He had personally ensured that the three additional Indiana asylums experimented with different designs – radiate, cottage, and pavilion/block—none of which was a Kirkbride/linear plan. Thus, in 1883, after working for four years at the linear-planned Indianapolis asylum, he had already judged Kirkbride's model less effective and desirable than models with detached parts. In recounting a thumbnail history of insane asylum design to his AMSAII audience in 1900, Rogers stated that cycles of expansion of admissions with resulting construction of new buildings to house the numbers of patients created the need for detachment and drove the trend toward housing more patients in dormitories of up to 100 patients. The linear plan could not compete with detached blocks/pavilions, or cottages as a flexible model adapting to growing populations.[271]

At this point in his career, Rogers did not entertain any illusions about the limitations of institutional design or life, and acknowledged the limitations of the detached building plans: "You may break, you may scatter the parts as you will, but the stamp of the institution will still hang around it."[272] All in all, his 1900 speech reveals a mature practitioner who still believed in the potential of moral treatment is it were adequately funded to be provided in all of its adaptable agencies.

Following his 1900 presidency of AMSAII, Joseph Rogers spent six more years directing operations at Longcliff. He developed serious renal disease and spent his last two years of life as an invalid, still living at Longcliff while Dr. Fred W. Terflinger acted as Medical Superintendent. When Rogers died on April 11, 1908, the state of Indiana paid his

[271] Ibid., 4.
[272] Ibid., 6.

funeral expenses (his grave marker is simple); he was buried not in the asylum cemetery but in Mount Hope cemetery, across the Wabash at another piece of high ground in Logansport.[273, 274] In this final act, Indiana may have demonstrated in a small way its moral obligation to Rogers and his family for the sacrifices they had made for 20 years in service to the public.

[273] Minutes of the Board of Trustees, April 11, 1908.
[274] Find A Grave website, http://www.findagrave.com/cgi-bin/fg.cgi?page=gr&GSln=Rogers&GSiman=1&GScid=86017&GRid=34865790&. Accessed October 10, 2014.

Chapter 5:
Stored Sauerkraut and the Pragmatics of Moral Treatment:
Some Concluding Reflections

This study has engaged historical and bioethics methods in examining the moral treatment movement and Longcliff Hospital under Joseph G. Rogers. It is time now to reflect on what this journey has ethically uncovered. Given that bioethics theory today does not usually involve historical studies, with the important exception of Jonsen and Toulmin's historical account of casuistry,[275] the exercise of facing the historical landscape free from bioethical academic norms led to some surprises. It became clear that in the nineteenth century, medical ethics in the alienist/psychiatric literature was not a matter of principlism as we know it today. Nor was the moral treatment provided to thousands of patients by the state at hospital-centered campuses discussed at the time as having public-health-ethics aspects *per se*. This study has revealed that what was bioethics, in substance if not in name, was not a matter of articulating the revered quartet of beneficence, non-maleficence, justice, and autonomy. Rather, the evidence speaks to benevolence instead of beneficence; economy and thrift instead of justice; and unashamed, compassionate paternalism instead of autonomy. It tells a story about what may be the birth of public health ethics as an exercise in compromise and the corresponding story of the death of a medical and social idyll. And as in any inquiry worth its salt, it led to more questions than it could answer.

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[275] Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: a History of Moral Reasoning* (Berkeley: University of California, 1988).

This study among other things tells a story of one leader making a difference, of a doctor in charge of a public hospital who created and tried to maintain it as a total environment, whose decisions affected thousands of people and their families over twenty years. Of course, he did not accomplish all of this alone, but he gave nearly his entire self, it would seem, to the task of directing the place and further, he seems to have been conscious of the population-level effect his smallest decisions would make. This perspective on Rogers as a moral agent, and his own self-awareness of the power of his position (in addition to his moral distress at its limitations), should suggest to us the tremendous power of bioethics discourse in the public provision of treatment for the mentally ill. If nothing else, this paper aims to prompt us to rethink the role of benevolence in care for the mentally ill that the state provides today. Perhaps it is past time to condemn paternalism and appreciate instead the integrated concept of benevolence that operated in the moral treatment movement, and think about how using an historical sense of benevolence might suggest ways that an adapted moral treatment might work today, in the limited hospital campuses still run by states, and even in outpatient settings.

This study in a small way has attempted to explore what historical-bioethical study, perhaps as a new subgenre of bioethics, could do for the field. Let us reflect on the main themes of bioethical significance.

Benevolence v. Beneficence, or Why We Need Historical-Bioethical Studies

Beneficence is such a commonplace today in bioethics discussions, and benevolence so conspicuous by its absence, that the most obvious question raised by this study may be: what is the difference between benevolence and beneficence? Does it make sense that alienists like Rogers spoke only of benevolence, while today's psychiatrists and bioethics

committees speak only of beneficence? What do these terms mean now, and what did benevolence mean in Rogers's day? For clues to the answer to these questions, *Principles of Biomedical Ethics*[276] provides the appropriate place to start.

Beauchamp and Childress present beneficence as a principle, or action guide, and benevolence as a roughly corresponding character virtue from the tradition of virtue or character ethics, which focuses on the moral character of the person who performs actions.[277] They also advocate considering how moral agents might combine character virtues and principles, as action guides, to make judgments and act on them. In other words, they ask us to consider the question, "what would a virtuous moral agent do?"[278]

Joseph Rogers in his role as Medical Superintendent fits this description as a virtuous moral agent, and the historical record indicates that he would have answered as a pragmatist: "[E]very reasonable thing I can think of and turn my hand to, within my authority and insofar as I can persuade the state to support it, I as an exemplar of benevolence must endeavor to do to help my patients to improve their health and comfort." Benevolence in nineteenth-century institutional expressions seems to have implied both character virtue for moral agents (the public, society, physicians, families), a duty to care for the sick and sustain the poor, and the corresponding actions. To Dorothea Dix and others who saw a chance at moral redemption in society's inadequate care for the poor and unfortunate, a benevolent society was one that demonstrated its virtue, its good will toward others, by taking action to solve the problem. The Quakers' actions in establishing the York Retreat illustrates this integrated concept of benevolence as virtue, duty to care, impetus to act, and normative

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[276] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Sixth Ed. (Oxford: New York, 2009).
[277] Ibid., 30-35, 45.
[278] Ibid., 45.

standard of behavior. In sum, benevolence understood to be more than "a character trait or virtue of *being disposed to act* for the benefit of others," (emphasis added) as Beauchamp and Childress define it.[279] Rather than being a static quality or the impulse to do good, it informs the entire package of moral agent, purpose, reasoning, action, and even style or quality of action.

Etymology also clarifies the difference between *benevolence* and *beneficence,* both of which came into use in English in the 1400s. *Benevolence* derives from the Latin roots *bene* ("well") and *velle* ("wish"), and from the Latin *benevolentia,* meaning "good feeling, good will, kindness."[280] By contrast, although it shares the Latin room bene ("well"), *beneficence* derives from the Latin root *facere* ("to do"), and from the Latin *beneficentia* meaning kindness and generosity.[281] The difference lies in how goodness is expressed—either as a wish or will, connoting an emotional and possibly spiritual engagement, or as a good deed, or well-intentioned action, or action that results in something good. So it would seem that today's principlism divides the multi-dimensional nineteenth-century concept of benevolence, keeping its meaning as a static quality, including an impulse to act; and imbues beneficence with the action role, consistent with its Latin origins. This focus we have on action has a transactional sense, utilitarian and divorced from the human compassion from which good will flows.[282]

While benevolence characterized the medical profession's self-image in the nineteenth century, since the American Medical Association's first code of ethics in 1847, the

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[279] Ibid., 197.
[280] Online Etymology Dictionary. http://www.etymonline.com/index.php?allowed_in_frame=0&search=benevolence&searchmode=none, accessed October 11, 2014.
[281] Ibid.
[282] Beauchamp and Childress, *Principles,* 196.

profession has spoken less and less of character virtues.[283] Thus it appears that terminology reflects contemporaneous ideas of what physicians should consider ethical conduct in their practice. Greater distance between psychiatrist and patient characterizes today's therapeutic relationship compared to the moral treatment's model, where the doctors lived at the hospital and shared the same campus if not the same level of privileges with the patients day to day. Certainly today it would be unusual for a psychiatrist in a state institution to think about which doorknobs would best bring beauty and comfort to her patients. Today's professional focus is on medication and its observable effects, a narrow focus that tends not to include every other aspect of the patient's activities and health as medical agencies. With an integrated and expansive concept of benevolence went greater compassion and willingness to get close to patients emotionally and spatially, to use the imagination in artistic and scientific ways to stimulate and soothe at the right times, in the right measures for individual patients. Without including historical studies in bioethics, we lose the opportunity to pay attention to words whose meanings we think are universal and timeless as they change slowly under our noses.

Pragmatism

This study of Joseph Rogers at Longcliff reveals pragmatism in its ordinary sense as a prominent quality of his practice of moral treatment, as he put it, "by every adaptable agency." This theme prompts the question whether the moral treatment movement and Rogers in particular had an association with the American pragmatist philosophy that emerged from the same period of history as Rogers's career as an alienist.[284] Indeed as will

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[283] Ibid., 35.

[284] Notably, Joseph Rogers's life span (1841-1908) coincided with that of American pragmatist philosophers Charles Peirce (1839 – 1914) and William James (1842 -1910). John Dewey's life far exceeded the others in length and extended halfway through the twentieth century (1859 – 1952).

be discussed further here, pragmatism stands as a philosophy to which Joseph Rogers himself could and may have subscribed, although the records reviewed for this study did not disclose any explicit thoughts on this issue. Since Rogers did not express himself specifically on the ideas of his contemporaries Charles Peirce, William James, and John Dewey, we have to look to his behaviors as documented in the historical record to judge whether he is likely to have agreed with their thinking. The records reviewed for this study did not disclose any specific suggestion that Rogers read, heard, met, or knew James, Peirce, or Dewey, but it is certainly possible that he was familiar at least with James's philosophy of psychology. Further research into this possibility of influence by the American pragmatism movement on Rogers would be worthwhile. A possible converse influence also compels further study—whether the pragmatist philosophers (especially James, who suffered from depression[285]) were influenced by the moral treatment movement. For our purposes here, it will have to suffice to explore the relationship between moral treatment and pragmatism at Longcliff.

Unity of Experience, Thought, and Action

From a bioethical viewpoint, insofar as moral treatment at Longcliff expressed benevolence in its multi-faceted nineteenth-century meaning, it was grounded, driven, shaped, and permeated by a commitment to human healing and flourishing. Moral treatment in all of its intended hospital-based multi-dimensional aspects exemplified a pragmatistic solution to the problem of caring for poor and dependent mentally ill persons, not only as a social experiment but also as an institutional expression of the idea that the human mind is inextricably related to its environment and that all kinds of experiences contribute to thinking and the formation of beliefs. Although pragmatism does not concern

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[285] John P. Murphy, *Pragmatism: from Peirce to Davidson* (Boulder: Westview Press, 1990), 14-16.

itself primarily with the disordered mind, it conceives of mind as multi-dimensional and integrated, and philosophy of mind as encompassing thought, action, and all other forms of human experience in stark contrast to the ancient Greek tradition of separating thought from action, mind from body. Moral treatment sought to situate persons with disordered minds in a specially-designed environment where they could not only recreate their daily life activities but the functions and equilibrium of their minds, bodies, and souls.

The life Joseph Rogers led as medical superintendent of Longcliff was consistent with the Deweyan idea that human flourishing results from creative unity of thought, belief, action, and experience. Rogers demonstrated time and again that no problem facing the hospital was too big or small for him to take on. He exerted himself in his relations with patients, their families, staff, the state, the Board, colleagues, and all of the vendors and other service providers on whom the hospital operations depended for the benefit of the patients and the hospital. John Dewey's comments on virtue sum up this sense of benevolence as Rogers demonstrated it in his life at Longcliff:

> To possess virtue does not signify to have cultivated a few namable and exclusive traits; it means to be fully and adequately what one is capable of becoming through association with others in all the offices of life.[286]

William James, in his only published paper on ethical theory, "The Moral Philosopher and the Moral Life," wrote that

> [T]here is no such thing possible as an ethical philosophy dogmatically made up in advance. We all help to determine the content of ethical philosophy so far as we contribute to the race's moral life. In other words, there can be no final truth in

[286] A. H. Johnson, *The Wit and Wisdom of John Dewey* (Boston: Beacon Press, 1949), 21, citing John Dewey, *Democracy and Education* (New York: MacMillan Co., 1916), 425.

> ethics any more than in physics, until the last man has had his experience and said his say.[287]

Going into the medical superintendent role at Longcliff in 1888, Joseph Rogers was equipped with guidance and resources such as the AMSAII/Kirkbride standards, a cultural concept of benevolence, his own experience at Indianapolis, and the advice of colleagues; but he understood the daily challenges of operating the hospital as creatively challenging to all of his faculties including his morals. In 1900 Rogers delivered with the confidence of his experience his considered judgments about how best to run an asylum in view of all the common practical realities and limitations. Ethics was inextricable from decisions about building design, staff hiring and firing, medical care, personal liberties, and the location of stored sauerkraut. Dewey wrote, "It is only as our ideas about morals…become part of the working behavior of the mind towards its concrete duties, that they are other than curiosities for the collector of the bric-a-brac of thought."[288] It is difficult to see Joseph Rogers as a man who would be content to apply moral ideas the equivalent of cheap purposeless trinkets to the practical problems he encountered in running Longcliff. His ideas about morals had to be sturdy and flexible enough to apply to every imaginable problem, beautiful in their utility instead of mere conceptual ornaments.

Life of a Medical Superintendent as Inquiry

Dewey argued that real thinking is active problem-solving and that solving a problematic situation satisfactorily results in knowledge. The development of knowledge via inquiry can then direct actions.[289] Dewey practiced his tenet that no problem is too small or

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[287] John J. McDermott, ed., *The Writings of William James* (Chicago and London; University of Chicago Press, 1977), 610-611.

[288] John Dewey, *The Philosophy of John Dewey* (New York: Henry Holt & Co., 1928), 317.

[289] Johnson, *Wit and Wisdom*, 17.

insignificant for thought and solution through action, turning his mind to all manner of issues in his long career. By this standard, a medical superintendent had to be a thinker, problem-solver, and experimentalist-doer.

From a pragmatistic viewpoint like Rogers's, the state mental hospital was an enterprise engaged in scientific inquiry for moral purposes, and therefore the life of a Medical Superintendent was a life of inquiry. Dewey wrote, "Science is a tool to be used, not a deity to be worshiped. Science is interested in 'those connections of things with one another that determine outcomes and hence can be used as means.'"[290] Rogers and other alienists saw moral treatment as a scientifically demonstrated improvement over the strictly physical treatments that preceded it, as well as a moral improvement in that it caused less harm, discomfort, and indignities to patients. The scientific method was a morally imbued practice and continuous experiment that uses reflection to assess risk of harm, avoid or minimize predictable harm, and maximize human comfort and growth.

Moral Aesthetics: Recreational Activities as Re-creating Life

As we have seen, moral treatment was based on an Enlightenment concept of mind as developed via sensory stimuli and response, via the work of Locke, Condillac, and Pinel among others. Mental health is a state of being including and affected by multiple activities of life and environment, all of which send sensory stimuli to the brain. Moral treatment theorized that the activities of life including work, rest, play, food, medical care, and socializing could be designed and coordinated to heal the disordered mind and wounded

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[290] Ibid., 13, citing John Dewey, *Experience and Nature* (New York, W. W. Norton and Company, 1929), v.

soul. In this scheme of things, activities undertaken primarily for pleasure had a special role to play.

Joseph Rogers enjoyed a lifelong personal fondness for music and dance, and exerted himself to ensure that patients would have the opportunity to engage in music and dance if they wished. On this point he exemplifies John Dewey's view of artistic engagement as powerfully life-giving, beyond passive entertainment or even the provision of stimulation and soothing that patients needed:

> Art…is more than a stir of energy in the doldrums of the dispirited, or a calm in the storms of the troubled. Through art, meanings of objects that are otherwise dumb, inchoate, restricted, and resisted are clarified and concentrated, and not by thought working laboriously upon them, nor by escape into a world of mere sense, but by creation of a new experience.[291]

A genuine work of art is an experience, whereas things like paintings or musical scores are "art products." As Dewey sees it, one cannot have an esthetic experience with an art product unless one engages in a process of re-creation, making a unique new experience of one's own.[292] In Dewey's view, such an experience involves "a creative ordering of diverse elements in such a fashion that completeness and unity are attained." A distinctively esthetic experience, as opposed to a practical creative experience which serves a specific problem-solving purpose, serves the purpose of enhancement of life in general.[293] Such an esthetic experience brings peacefulness, a sense of there being something beyond the immediate situation, and awareness of the interconnectedness of things.[294] Dewey believed that esthetic experience is an essential need for everyone, since it is one of the primary ways one can enrich life. Joseph Rogers not only agreed with the value of artistic pursuits for state mental

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[291] Ibid., 84, citing John Dewey, *Art as Experience* (New York, Minton, Balch & Co., 1934), 132-3.
[292] Johnson, *Wit and Wisdom*, 22
[293] Ibid., *Wit and Wisdom*, 23.
[294] Ibid.

hospital patients but repeatedly advocated to the Board to make them available as an indispensable part of moral treatment.

Important as artistic activities were to moral treatment, however, Dewey's most important point about art is that daily living itself can be an art. Life integrating thought, morals, and action is the ultimate artistic experience.[295] If this is true, the record of Joseph Rogers's career suggests that the state mental hospital delivering moral treatment *required* doctors in the role of medical superintendent to apply creative adaptation and moral attentiveness to just about every aspect of life.

Asylum as School, Medical Superintendent as Educator

Dewey conceived of thinking and knowing as practical activities that cannot be separated from an organism's adjustment to its environment. Rogers saw a patient's experience at Longcliff as one of continuous adjustments to the environment. In pragmatism the term "mind" does not refer to a faculty dissociated from natural processes but a complex whole that includes idiosyncratic systems of meanings resulting from previous experiences that serve to inform and influence one's responses to present problems.[296] The asylum could serve as a re-educating environment, like a school. According to Dewey, "the educator's part in the enterprise of education is to furnish the environment which stimulates responses and directs the learner's course."[297] Dewey's views on educators describe Rogers's view of himself as the hospital design engineer and director of treatment at the hospital. Hence, since his job as medical superintendent is like that of a school principal or

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[295] Murphy, *Pragmatism*, 65.
[296] Johnson, *Wit and Wisdom*, 18.
[297] Ibid., 32, citing John Dewey, *Democracy and Education*, 212.

superintendent, the critical importance to Rogers of providing the properly equipped and designed environment.

On this point it is important to appreciate that Dewey's concept of what a school could and should be for students differed starkly from previous models. Dewey's model aimed to direct natural activities along a coherent line of development where traditional schools imposed set programs on students.[298] To Dewey, as to Rogers, self-discipline is not externally imposed but externally modelled and internally nurtured.[299] Joseph Rogers understood the hospital to be the environment he created and sustained in which and by which patients could re-create balanced, healthy lives by creating new experiences. Through these lived experiences, they would develop the skills, habits, and knowledge to return home where they could continue to live well or better than before their admission. This model of a formative environment sheds light on Rogers's refusal to classify chronically ill patients as "incurable," for if the hospital serves as the environment for development of a patient's mind, it must not employ a classification that undermines that purpose. In pragmatism, a classification must serve a specific purpose. It follows that the hospital must never give up hope on cure or at least improvement.

Restraints and Moonstruck Morals

As a virtuous alienist who had to deal with public opinion and the sensationalizing tendencies of the newspapers, Rogers understood that the use of individual mechanical restraints on patients tested the ethical fiber of an asylum like no other issue. Dewey summed up the essence of the problem of unrealistic thinking about the use of force to

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[298] Ibid., 32.
[299] Ibid., 33.

accomplish any end, which for our purposes can include benevolent ends: "No ends are accomplished without the use of force. It is consequently no presumption against a measure, political, international, jural, economic, that it involves a use of force. Squeamishness about force is the mark not of idealistic but of moonstruck morals."[300] To Dewey, moral reasoning that does not solve a practical problem offers little to respect. To Rogers, the use of force such as applying restraints was a last resort to be used only under a doctor's orders and to serve a beneficial purpose, such as to enable the patient to sleep or protect him from self-harm. Restraints could also serve the purpose of preventing harm to others by a patient unable or unwilling to restrain himself. It should be done without anger and not as punishment, in order to avoid inflicting harmful emotional damage on the patient. Rogers made decisions about the use of restraints as considered judgments and had to account for them in writing to the Board and the Governor, the collective stewards of the hospital.

Thrift: A Concept for Further Inquiry

In addition to raising important issues about benevolence and pragmatism, this study also reveals economizing as a major challenger to benevolence. Rogers's response to the money-saving interests of the state was thrift as a means for balancing competing interests in a creative and possibly even artistic way. For example, Rogers demonstrated thrift by growing food at the hospital farm, engaging patients in productive work, and serving the most nutritious meals possible at the lowest price. His concern with documenting the income and expenses of the hospital and justifying every unplanned expenditure manifests consistently throughout his reports to the Board and the Governor.

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[300] John Dewey, *Character and Events* (New York: Henry Holt & Co., 1929), 787.

In view of the holistic concept of "benevolence" that we have noted operating in the nineteenth century, we should also consider that thrift might also have been understood and practiced as an integrating ethical concept. Could Rogers have practiced thrift as an integrated ethical model of virtue, impetus, duty, and action? This question deserves further historical and ethical study.

Principal and Agent

In moral treatment, benevolence extended to the architecture and grounds and everything and everyone on the premises. While Rogers and his colleagues endeavored to demonstrate that any agency, from window screens to rocking chairs, could be specifically adapted to the therapeutic benefit of the mentally ill at an asylum, we have not yet interrogated the claim of agent status in Rogers's pragmatic principle "by every adaptable agency." If by definition every agent has a principal who delegates authority and gives instruction, who or what did Rogers deem that principal to be?

Can the principal be a principle or concept? If so, could the principal have been benevolence? This proposition has some merit. Rogers saw the hospital and all its trappings as therapeutic interventions expressing benevolence. The limitation of this idea lies in the responsibility that a principal owes to its agent to give direction and set limits. A concept like benevolence is too theoretical to enable a faithful agent to fulfill its obligations to solve specific practical problems.

Looking to a human principal, could the alienist be the principal? The record does not indicate that Rogers expressly considered the alienist as the principal but the context of his phrase "by every adaptable agency" in his 1883 speech on the therapeutics of insanity support an implication that he believed this. His audience was a group of physicians, his subject the care of patients experiencing acute mania ("wear and waste"), for which the indications of rest and food were to be secured by every adaptable agency—tangible and intangible, physical, mental, and moral.[301] (At this stage in the career of moral treatment, and given the context of Rogers as the speaker, "moral" may have meant both affective and ethical.)

Once again, Deweyan pragmatism helps us to answer this question. Pragmatism says that agency must be specific to a purpose, and if this is true, then so too must a principal. If the agent's purpose is morally driven, the principal must be a virtuous moral agent. If the details of Longcliff's operation, such as doorknobs made according to Rogers's own design, manifested his cognitively, morally, and technically specific solutions to problems, and the problem was how to care for mentally ill patients while respecting their dignity and allowing them as much personal liberty as possible, then the principal must have been he. If the medical superintendent is the principal, since he works for the state, then he must represent the people of Indiana. In other words, the medical superintendent is a moral agent of a moral principal, the people of Indiana. And those people must include mentally ill patients of Longcliff. In sum, "every adaptable agency" serves the benevolent goals of the people and the patients themselves.

One Last Perspective: Moral Treatment in the Melon Patch

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[301] Rogers, "Report on the Therapeutics of Insanity," 344.

Pragmatism argues that every agency serves a specific purpose. At the direction of a virtuous moral principal (in the sense of being a moral agent), every action can carry moral influence or contribute to a moral outcome. Dewey claimed that "every act has potential moral significance, because it is, through its consequences, part of a larger whole of behavior."[302] If taken out of context, any one of Joseph Rogers's actions as discussed in this study easily loses its sense of moral significance. Viewed through historical and bioethical lenses and taking account of the whole of his behavior as an alienist and medical superintendent, however, even the most seemingly irrelevant action resonates with the vibrancy of his moral drive.

Therefore it seems right to give Dr. Rogers the last word from the farthest reach of the Longcliff grounds where one might expect a report of virtuous action: a melon patch. In spite of the depth of human pain to which Longcliff was home and the relentless series of setbacks and compromises he had to manage, Rogers's capacity for perspective enabled him to find humor in a situation arising in the melon patch which he shared with the Board in his September 1890 report. If the reader has gained any new understanding from this study, the moral significance of the following excerpt should come to mind:

> The nightly raids of some unknown vandals in the melon patch two weeks or more ago, resulting in the useless destruction of a hundred or more green melons each time made it necessary to engage a special watchman, as much to sustain the reputation of the Management as for the preservation of the fruit. Several hot battles ensued but the enemy seems to have finally retired from the field and I have disbanded my little army of one man. The honor of the institution has been sustained—the melons have been allowed to ripen and are now being eaten by the inmates in liberal amount.

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[302] Donald Morris, *Dewey and Behavioristic Context of Ethics* (San Francisco: International Scholars Publications, 1996), 12, citing John Dewey and James H. Tufts, *Ethics*, rev. second ed. (New York: Henry Holt & Co., 1932), 179.

A seemingly mundane event bears profound moral significance from the pragmatistic viewpoint of moral treatment. Dr. Rogers could have let the trampled melons rot in the patch. He could have let the vandals triumph and told the Board nothing about the whole thing. Yet he chose to take specific meaningful action to protect a resource of nutritive and recreational value and to deter further raids on the state's assets. He understood the healing power of a simple pleasure, of fresh food. As a result of his actions, on at least one hot Indiana summer day, hundreds of patients of Longcliff Hospital enjoyed the refreshment of eating sweet, ripe melons that some of them had gathered, and there was plenty to go around.

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