

Tuberculosis in Town: Mobility of Patients in Montreal, 1925–1950

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In the second quarter of the twentieth century, the ideal management of tuberculosis called for confinement and immobilization of the patient over a span of one or more years. At the same time, North American cities were being redeveloped in ways that promoted great personal mobility. From a compilation of 300 cases of tuberculosis patients in Montreal, the authors explore the contradictory pressures on urban working people, the resistance they mounted, and the coping strategies their families used to maintain much-needed mobility. Professionals' prescriptions for isolation and immobilization were undermined by a scarcity of resources for public action, producing a gulf between the ideals of modern public health and the realities of urban life.

Durant le deuxième quart du XX^e siècle, la gestion idéale de la tuberculose exigeait l'immobilisation du malade pendant un an ou plus. En même temps, les villes nord-américaines vivaient des changements majeurs axés sur une augmentation importante de la mobilité personnelle. Dans un ensemble de 300 cas d'étude montréalais,

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les auteurs observent les pressions contradictoires exercées sur les tuberculeux, ainsi que la résistance qu'ils pouvaient leur opposer et les manœuvres que leurs familles pouvaient faire pour défendre une mobilité nécessaire à leur survie. Les demandes des médecins en matière d'isolement et d'immobilisation se butaient à un manque de ressources, produisant un gouffre entre les idéaux de la santé publique moderne et la réalité urbaine.

IN NOVEMBER 1928, Dr. Landes of the Royal Edward Institute diagnosed Bernie X with tuberculosis in both lungs. Within a week and a half, Bernie was admitted to the Mount Sinai Sanatorium in Sainte-Agathe-des-Monts. Six months later, however, his “rest cure” came to an abrupt end when his friend John announced he could no longer contribute \$20 a month toward Bernie’s care. With a weekly income of \$18, two young children, and a medical bill outstanding at one of the city’s children’s hospitals, John found it impossible to continue supporting Bernie’s hospitalization, and the medical staff judged Bernie well enough to return to Montreal. Three months following Bernie’s discharge, a doctor at the Herzl Dispensary recommended readmission, and it took another month to arrange his stay. Altogether, Bernie spent nearly 500 days at the institution before his tuberculosis was deemed in remission and he was again returned to the community.¹

Today, a diagnosis of tuberculosis in Montreal initiates immediate isolation of the patient, obligatory reporting, and contact investigation by public health authorities. Within a matter of weeks, a carefully planned drug cocktail has arrested the contagious phase, and the average patient is recovering energy, regaining weight, and feeling ready to go back to work or to school.² Until the early 1950s, however, when antibiotics were introduced, outcomes were very uncertain, and half of the cases formally reported led to death within a year or two. Because so many sufferers remained contagious for months or years, medical authorities agreed on the need to isolate the patient for a similar length of time. Even as drug therapy spread in the 1950s (improving gradually in efficacy), ideal management of tuberculosis still called for confinement and immobilization along with drug therapy. Over the period under study, the populations of both Canada and the United States were moving in massive numbers to cities, and the revolutions of tramways and the motor car led to great leaps in personal mobility.³ The requirements of public health and the possibilities of urban living thus came into increasing conflict.

1 Canadian Jewish Congress Charities Committee National Archives, MB2, Series B, Box 2, Herzl Dispensary, Medical case file 1027. The series, including Mount Sinai Sanatorium patients, 1930–1958, is hereafter entered as CJCCNA X-files. Names have been altered.

2 H. Njoo, “Tuberculosis: A Re-emerging Public Health Threat in Canada,” *Canadian Journal of Infectious Diseases*, vol. 9, no. 5 (1998), pp. 273–275.

3 Yves Bussière, “L’automobile et l’expansion des banlieues : le cas de Montréal, 1901–2001,” *Urban History Review*, vol. 18, no. 2 (1989), pp. 159–165; Stephen Davies, “Reckless walking must be

Taking both quantitative and qualitative approaches to the problem, we direct attention to the dimension of epidemiological risk associated with twentieth-century mobility, the way it was perceived, and the pressure to ignore or defy risk. By examining the contradictory demands on families of tuberculosis patients between 1925 and 1950, we explain the gulf between public health ideals and the realities of urban life. How successful, we ask, were physicians and authorities in eliciting patients' cooperation, restricting their movement, and interrupting transmission?

Case files from Montreal institutions provide evidence for patients' resistance to the strictures imposed on them. These histories are drawn from clinical settings where most patients were urban working people under severe budgetary constraint. They amounted to perhaps half the population. Our objective is to assess what low-income urban families were experiencing, but the attempt is limited by our dependence on institutional records created by social workers and medical personnel who inevitably imposed a "filter" on individual "voices." To identify the points at which the medical ideal broke down, we observe patients' movements between domestic and institutional spheres. As we shall see, resources were not sufficient to make the treatment model workable; both homes and institutions were inadequate to the task of isolating the individual, and consequently patients — and their microbes — were more mobile than ever.

In well-off households, a patient could be isolated with relative ease because individuals had separate bedrooms, servants did much of the domestic work, nurses could be hired, and the doctor came to the house. Further, the sick person could travel in relative comfort to take advantage of a hospital or sanatorium with a private room. Peter Redpath, whose family had made a fortune in sugar, took rest cures at spas and hotels in Europe, New York, Colorado, and Redlands, California, where he eventually succumbed to the disease.⁴ The family of 17-year-old George Eric Dawson (a grandson of the principal of McGill University) adapted its residence to minimize risk to his nine brothers and sisters. Eric's mother arranged a separate wing with rooms that could be ventilated and disinfected. For two years, she accompanied him to their summer residence

discouraged": *The Automobile Revolution and the Shaping of Modern Urban Canada to 1930*, *Urban History Review*, vol. 18, no. 2 (1989), pp. 123–138.

⁴ See Amy Redpath's diaries at McGill University Rare Books, MS 659, Roddick, Sir Thomas — Amy Redpath (1897–1902). The Redpath family correspondence is also revealing of Peter's illness and pursuit of treatment. See also McGill University, Rare Books, MS 818 c.1, Redpath Family, File 1.2a, Redpath Family Correspondence; c.2, Redpath Family, File 2.13, Redpath Family Correspondence, Grace (Mrs. Peter) Redpath; and c.2, Redpath Family, File 2.36, Letters from Friends and Family, Peter Whiteford Redpath.

at Little Métis and to health resorts such as Saranac Lake. Despite these efforts, Eric died.⁵

The story on which we focus is that of the larger group of patients who relied on their weekly earnings or exhausted their small savings, lived in cramped spaces, and, in the struggle with tuberculosis, had to move around the city to seek treatment from various facilities. After outlining the institutional context in Montreal and the sources tapped, we describe the “fresh air model” for management of tuberculosis, the demands it made on the patient, and its implications for rethinking the urban environment. We then draw on case histories to explore the difficulties families encountered with one option presented to them: confinement to the home. Finally, we consider the problems associated with the other option: isolation in a rural institution. Each option set up specific demands and constraints in terms of mobility. Faced with a disease of slow and uncertain evolution, families manoeuvred a course of compromise.

The Institutional Framework

Studies of sanatorium design have, for the most part, featured institutions in rural settings.⁶ Patients’ letters, as well as novels such as Thomas Mann’s *The Magic Mountain*, have articulated the experience of patient life in the sanatorium, but such documents refer primarily to private institutions, remote locations, and affluent patients. An exception is Sholem Shtern’s *The White House*, a novel first published in Yiddish verse, based on his experience as a patient in the Mount Sinai Sanatorium.⁷ Shtern wrote

5 According to a study by Annmarie Adams and Peter Gossage, Eric suffered from a variety of illnesses before his death from tuberculosis. His mother, Anna Harrington, nursed him through his numerous maladies. See “Sick Children and the Thresholds of Domesticity: The Dawson-Harrington Families at Home” in Marta Gutman and Ning de Coninck-Smith, eds., *Designing Modern Childhoods: History, Space, and the Material Culture of Children* (New Brunswick, NJ: Rutgers University Press, 2008), pp. 65–69.

6 On design of sanatoria and hospitals caring for tuberculosis patients, see Annmarie Adams and Stacie Burke, “‘Not a shack in the woods’: Architecture for Tuberculosis in Muskoka and Toronto,” *Canadian Bulletin of Medical History* [hereafter *CBMH*], vol. 32, no. 2 (2006), pp. 429–455; Annmarie Adams and Mary Anne Poutanen, “Architecture, Religion, and Tuberculosis in Sainte-Agathe, Québec” (paper given at the Canadian Society for the History of Medicine Annual Conference, York University, 2006); Annmarie Adams and David Theodore, “Designing for ‘The Little Convalescents’: Children’s Hospitals in Toronto and Montreal, 1875–2006,” *CBMH*, vol. 19, no. 1 (2002), pp. 201–243; Jeremy Taylor, *The Architect and the Pavilion Hospital: Dialogue and Design Creativity in England, 1850–1914* (London: Leicester University Press, 1997); Leslie Maitland, “The Design of Tuberculosis Sanatoria in Late Nineteenth Century Canada,” *Society for the Study of Architecture in Canada Bulletin*, vol. 14, no. 1 (1989), pp. 1–13.

7 Sholem Shtern, *Dos Vaisse Hoiz* (1928), translated as *The White House* (Montreal: Warbrooke, 1974). The culture of the sanatorium is explored in Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994); Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign against*

about fellow patients, most of them from the working class, their personal encounters with the disease, its treatment, and their isolation in the countryside. Our challenge was to find sources that would enlarge our understanding of the disease and its treatment as part of everyday urban life. To meet this objective, we selected 300 case histories of patients who lived in Montreal and who belonged to the poorer half of the population. Here we consider the ways in which Montrealers may have resembled residents in other North American cities or differed from them, situate the institutions upon whose records we draw, and appraise the limitations of this sample of cases as a strategy for penetrating the range of experiences of so large and diverse a population.

As Canada's largest manufacturing centre throughout the quarter-century of this study, Montreal had about half the waged workers of the Province of Quebec, a strong component of low-wage industries (shoes, garments, textiles, and tobacco) and a low rate of unionization. In 1931, one-fifth of the population had been born outside Canada. The labour force was considered notoriously "docile" and easily "satisfied," thanks to an "inexhaustible" pool of "cheap labour" from the surrounding countryside.⁸ Over the period under study (one generation), the population grew from 819,000 to 1.1 million people,⁹ and 15,600 deaths were attributed to tuberculosis. The annual numbers of deaths from the disease fell gradually from 1,000 to 400, as shown in Figure 1. New cases were reported at about the same rate, but the actual number of infectious "consumptives" was estimated at ten for every death, or on the order of 150,000 for the study period. This means that a large share of families (with a mean size of five persons) were, at some point, coping with a case of active disease, often the father or the mother. Increasing the severity of the problem was the fact that tuberculosis cases tended to be reported at a later stage, resulting in poor prognoses; hence death rates were 50 per cent higher in Montreal than in Toronto, for example. The slow decline

Tuberculosis in Canada, 1900–1950 (Montreal: McGill-Queen's University Press, 1999), pp. 254–255; Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876–1938* (Philadelphia: University of Pennsylvania Press, 1992); Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, NJ: Rutgers University Press, 1995); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, MA: Harvard University Press, 1996); Susan Sontag, *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1978); Louise Côté, *En garde! Les représentations de la tuberculose au Québec dans la première moitié du XX^e siècle* (Sainte-Foy: Presses de l'Université Laval, 2000); Claudine Pierre-Deschênes, *La tuberculose au Québec au début du XX^e siècle : problème social et réponse réformiste* (mémoire de maîtrise, Université du Québec à Montréal, 1980).

⁸ Andrée Lévesque, *Virage à gauche interdit* (Montréal: Boréal Express, 1984), pp. 14f; Roma Dauphin, *Économie du Québec : une économie à la remorque de ses groupes* (Laval: Beauchemin, 1994).

⁹ The population of the Island of Montreal rose from 1.0 to 1.5 million, with increasing spillover beyond the Island.

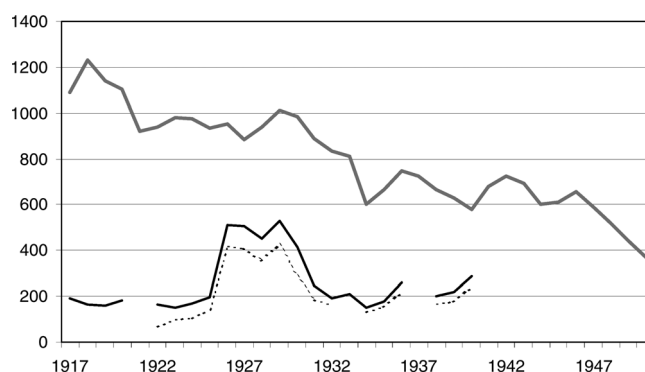


Figure 1: Annual numbers of deaths from tuberculosis, applications for subsidized beds and numbers recommended, Montreal, 1917–1950. Source: Ville de Montréal, Département de santé publique, *Rapports annuels*.

in Montreal paralleled other Canadian and American cities. Yet tuberculosis remained a major cause of adult deaths and a prime target of public health propaganda.¹⁰ Between 1920 and 1950, public health ideas and strategies were similar in Montreal and other cities. North and south of the Canada–United States border, the practice and teaching of medicine, the professional evolution of social work and nursing, and municipal approaches to town planning and public health were essentially the same.

This period experienced a rapid increase in urban mobility. To remain employed, people were becoming increasingly dependent on the ability to move around and to cover larger distances. Montrealers were heavily reliant on mass transit for going to work, shopping, and visiting family or the doctor; their rate of car ownership was about half that of Toronto and most large cities in the United States. By 1947, mass transit rides averaged one per day for every man, woman, and infant on the Island of Montreal (86 per cent of all vehicle trips were by mass transit). Extreme urban congestion meant that the new factories for munitions and war material (subsequently converted to other kinds of manufacture) had to be sited in relatively distant locations; hence journeys were lengthening and often included a trip on a bus that served as a feeder to the tramway. Although Montreal lagged behind American cities in postwar residential construction, much of its growth was located on the periphery.¹¹

10 For the first 30 years of the twentieth century, the primary concern of the Health Department was a very high infant mortality, calling for attention to breastfeeding, maternal care, safe milk and water, sewerage, and control of flies. At the time of the Second World War, a “mortality transition” had been achieved such that attention was redirected to heart disease and cancer.

11 Trips per person per year increased from 234 in 1931 to 307 in 1946. See Montreal Board of Research on Traffic and Transportation Problems, *First Report to the Municipal Council*, City of Montreal,

Since most Montrealers were renters (with 80 per cent having leases shorter than one year), a high proportion of households relocated each year. In short, both daily individual mobility and annual household mobility were high, and the distances covered grew longer.

In the years from 1925 to 1950, many Montreal households advanced from confinement to “a universe of need” towards “a universe of aspirations,” enjoying the benefits of a small discretionary income beyond the strictest necessities of food, shelter, and winter clothing. Households began spending more on foods processed outside the home (and on cigarettes), but the expenditures lagged well behind those of households in Toronto.¹² In 1931, a minimum survival budget was estimated at about \$1,000 per year; the income of Bernie’s friend John, whom we met earlier, fell near the threshold. As a result of the Depression, the average annual wage of Montreal factory workers had fallen from \$1,200 to \$777 between 1929 and 1933, about one-quarter of households lived in overcrowded dwellings in 1935 (with less than a room per person), and uncertainty of employment persisted to 1940. In the five years after the war, purchases of durable goods such as washing machines and radios reflected deferred spending of wartime savings.

The records used in this study concern individuals from a broad range of popular classes, extending well beyond what in present-day parlance would be called the very poor, with incomes considerably above what Statistics Canada defined as low-income cut-offs in 1937 to 1951. Since there was no public health insurance, prolonged sickness meant that families reliant on the weekly wage of a mechanic or the regular salary of a clerk exhausted their savings and fell into debt. The daily cost of hospitalization doubled in this period. Despite the initiation of federal interventions and the growth of much debate over the need for health insurance, Quebec was directing new funds for health exclusively to the construction of hospitals. Public assistance was provided only to people officially deemed indigent and was awarded not to individuals, but to the facilities in which they were treated. Cost recovery by the institution was well below the actual expenditure for care (making the indigent a second-class category), and doctors were expected to donate their services to make up part of the difference. By 1950, some provincial funds were

1949; Donald F. Davis and Barbara Lorenzkowski, “A Platform for Gender Tensions: Women Working and Riding on Canadian Urban Public Transit in the 1940s,” *Canadian Historical Review*, vol. 79, no. 3 (September 1998), pp. 431–465.

12 Mario Desautels, “De l’univers des besoins à l’univers des aspirations : la structure budgétaire des familles montréalaises, 1938–1959” in Pierre Lanthier and Guildo Rousseau, eds., *La culture inventée, les stratégies culturelles aux 19^e et 20^e siècles* (Québec: Institut québécois de recherche sur la culture, 1992), pp. 281–301; J.-P. Charland and J. Saint-Pierre, “Le pouvoir d’achat des travailleurs, 1929–1960. Quelques éléments d’évaluation,” *Recherches sociographiques*, vol. 30, no. 2 (1989), p. 209.

channelled to the organizations that deployed visiting nurses and nursing sisters (including the municipal health department), but they were paid below the hospital standard. The indigent — that is, those eligible for Quebec Public Assistance — comprised the great majority of patients in the sanatoriums.¹³

To be certified as indigent by the priest, city clerk, social worker, or physician meant undergoing repeated humiliations. Eligibility of a tuberculosis patient for a city bed, which was subsidized by public assistance funds, or for any unemployment relief (available during limited periods of the Depression) required resident status as well, and eligibility was jeopardized by any move for a spell of employment, to a mine in Abitibi, for example, or even to a suburban municipality such as Verdun on the Island of Montreal. Of those who were authorized for unemployment relief in the 1930s, about one-quarter showed clinical undernourishment; of those on assistance for five years, half were malnourished.¹⁴ In short, the quarter-century under review was a period of severe stigmatization of people known to be indigent as well as of those suffering from tuberculosis. Bernard Coleman, who authored the 1949 *Hospital Survey Report* of the Mount Sinai Sanatorium, acknowledged that consumptives seeking admission were reluctant to turn to the Family Services Bureau for assistance given the “stigma attached to applying for relief.”¹⁵

Under the formal segmentation of health and welfare services by language, ethnicity, and religion, which was more complex in Montreal than in Toronto, the politics of identity interfered with the redefinition of social policies and held back the adoption of measures of assistance to individuals. The tuberculosis patient required long-term care, and new needs emerged as families exhausted their resources. Although the (abundant) discourse on social welfare policies was not centred on tuberculosis, this disease in fact generated much of the pressure for the creation of hospital insurance, since the long stays had such dramatic effects on the economic viability of families, hospitals, doctors, and municipalities. In the same way, tuberculosis provided the impetus for integration of welfare services and for a shift to a public regime, which were to be key components of the Quiet Revolution in the 1960s.

13 Funding for TB “beds” under Quebec Public Assistance began in 1926. The proportion rose from 88 to 96 per cent between 1946 and 1958. Yves Vaillancourt, *L'évolution des politiques sociales au Québec, 1940–1960* (Montréal: Presses de l'Université de Montréal, 1988), p. 209.

14 The public assistance regime operated under legislation adopted in 1921. The numbers involved were compiled by Vaillancourt (*L'évolution des politiques sociales au Québec*); those for direct assistance (unemployment) by Lévesque (*Virage à gauche interdit*); see also Dorothy Aikin, “The Role of the Montreal Council of Social Agencies in the Establishment of Public Assistance” (typescript report, McGill University Library, University of Chicago, School of Social Service Administration, 1950).

15 Bernard S. Coleman, *Mount Sinai Sanatorium Hospital Survey Report 1949*, June 18, 1949, p. 17.

Until then, all health and welfare services, public assistance, and social case work were delivered by private and “voluntary” organizations on a segmented basis. Responsibilities were formally allocated in terms of linguistic, ethnic, and religious identity.¹⁶ In response to conflagration, flood, a fierce winter, an epidemic, or a factory explosion, it was taken for granted that each “race” would take care of its own. The Quebec government played a minor role in delivering health care and relied on private charities to fill in the gaps; it budgeted small and inelastic subsidies to the assorted hospitals and shelters. The municipal government saw its role only as that of coordinator. Its power to tax (restricted to an inflexible property tax) was not adequate to the basic requirements of public welfare even under normal conditions and especially during the crisis of the 1930s; the city’s attempts to meet the needs of the unemployed brought it to bankruptcy, and it remained under provincial *tutelle* or receivership for four years (1940–1944). As the unprecedented unemployment started to swell, emergency relief funds from municipal, provincial, and federal levels were channelled through the Saint-Vincent-de-Paul Society, the Montreal Council of Social Agencies, or the Federation of Jewish Philanthropies and were allocated to Catholics, Protestants, or Jews in exact proportion to the numbers reported in the last census (1921), namely 75, 19, and 6 per cent respectively.

Changes in the health system were underway, however. The activities of Metropolitan Life are indicative: the insurance company began to employ an important contingent of visiting nurses (from the Victorian Order of Nurses [VON] and the Sœurs de l’Espérance) to care for its working-class clientele.¹⁷ Quebec in general was tracking continent-wide trends

16 Huguette Lapointe-Roy, *Charité Bien Ordonnée : le premier réseau de lutte contre la pauvreté à Montréal au 19^e siècle* (Montréal: Boréal, 1987). Genuine cultural desegregation of schools, health, and welfare did not occur in Quebec until the 1960s, when these institutions were taken over by the state as part of a “quiet revolution.” On the role of the Quebec government before 1960, see Georges Desrosiers *et al.*, “Le renforcement des interventions gouvernementales dans le domaine de la santé entre 1922 et 1936 : le service provincial d’hygiène de la province de Québec,” *CBMH*, vol. 18, no. 2 (2001), pp. 205–240; on the reorganization of the 1960s, see Dominique Marshall, “Nationalisme et politiques sociales au Québec depuis 1867 : un siècle de rendez-vous manqués entre l’État, l’Église et les familles,” *British Journal of Canadian Studies*, vol. 9, no. 2 (1994), pp. 301–347; Jean Hamelin and Jean-Paul Montminy, “La mutation de la société québécoise, 1939–1976. Temps, ruptures, continuités,” in *Idéologies au Canada français 1940–1976*, #1 (Québec: Les Presses de l’Université Laval, 1981), pp. 33–72.

17 For more on these Metropolitan Life visiting nurses, see Denyse Baillargeon, “Les infirmières de la Montréalaise” in *Les bâtisseuses de la cité*, Actes du colloque “Les bâtisseuses de la cité,” Section d’études féministes, congrès de l’ACFAS 1992, Montreal, *Les cahiers scientifiques* no. 79 (1993), pp. 107–120; “Les rapports médecins-infirmières et l’implication de la Métropolitaine dans la lutte contre la mortalité infantile, 1909–53,” *Canadian Historical Review*, vol. 77, no. 1 (March 1996), pp. 33–61; and “Care of Mothers and Infants in Montreal between the Wars: The Visiting Nurses of Metropolitan Life, Les Gouttes de Lait, and Assistance Maternelle” in Michael D. Beheils, ed., *Quebec since 1800: Selected Readings* (Toronto: Irwin Publishing, 2002), pp. 193–209.

toward the emergence of hospital insurance, sick benefits from unions, and the professionalization of hospital management. Montreal employers, in particular, were adopting Blue Cross hospital insurance plans.¹⁸ With the diversification and specialization of institutions, fund drives were consolidated and professionalized, but the regrouping remained under tripartite religious auspices.

The primary sources consulted in this research are case files from two different institutions: 96 files from the Jewish Welfare Department (JWD) and 194 hospital records from the Royal Edward Institute (or REI, later called the Royal Edward Hospital and Royal Edward Laurentian Hospital and known today as the Montreal Chest Institute or MCI). Each set is a sample from a much larger number of records and is representative of the institution's patient population. The first set, found in the Archives of the Canadian Jewish Congress, is from a carton salvaged from an alphabetical sequence — referred to as X-files — compiled by social workers employed by the Federation of Jewish Philanthropies in their investigations of eligibility for assistance for a stay at the Mount Sinai Sanatorium.¹⁹ Most of the patients were referred by the Herzl Dispensary, the earliest in 1913, the bulk in the 1930s and early 1950s. Half a dozen files cover a period longer than a decade, and nearly a third (30 per cent) report at least one home visit of the social worker. We selected our second set from files at the REI, drawing five batches to distinguish out-patients (n = 104) from patients admitted to hospital (n = 90); in each batch, we randomly opened at least 30 files for the year 1939, 30 for 1947, and 30 for 1951. A set of 64 out-patients is of particular interest, since each patient's record was clipped together with information about all members of the family, 141 persons in all. It is not surprising to find many reports of close relatives who died of tuberculosis. A contact (exposure to someone with tuberculosis) was identified in half the cases.

18 In 1935, the mean annual contribution per person province-wide was 50 cents for sickness and accident insurance, a sum comparable to City of Montreal expenditure for health and sanitation. The former rose rapidly to 1960, while the latter did not. See Aline Charles, François Guérard, and Yvan Rousseau, "L'Église, les assureurs et l'accès aux soins hospitaliers au Québec (1939–1960)," *Société canadienne d'histoire de l'Église catholique, Études d'histoire religieuse*, no. 69 (2003), pp. 29–49; see also Yvan Rousseau, "Le commerce de l'infortune, les premiers régimes d'assurance-maladie au Québec, 1880–1939," *Revue d'histoire de l'Amérique française*, vol. 58, no. 2 (Fall 2004), pp. 153–186; François Guérard, "Les principaux intervenants dans l'évolution du système hospitalier en Mauricie, 1889–1939," *Revue d'histoire de l'Amérique française*, vol. 48, no. 3 (1995), pp. 375–401.

19 Social workers in the Federation of Jewish Philanthropies were especially active with juvenile delinquents. See Tamara Myers, "On Probation: The Rise and Fall of Jewish Women's Antidelinquency Work in Interwar Montreal" in Bettina Bradbury and Tamara Myers, eds., *Negotiating Identities in 19th- and 20th-Century Montreal* (Vancouver: University of British Columbia Press, 2005), pp. 175–201.

Although the two institutions were founded to serve the needy of the Jewish and Protestant communities, by 1925 they were handling diverse clientele: their first-line clinics were located in an inner city that attracted immigrants of various origins; they received patients referred by private doctors and by public health nurses under the direction of ten separate agencies (including insurance companies); and they were assigned responsibility for patients released from the sanatoria on their return to Montreal. Of the files examined at the REI, about one-third were initiated as records of contacts of active cases already under care in the institution, one-third from referrals of family doctors, and one-third from referrals by other hospitals and nursing groups. In the absence of comparable files for the Hôpital Sacré-Cœur, which served a largely Catholic clientele, we draw for comparison from the more comprehensive annual reports of the municipal health department and the Institut Bruchési.²⁰

The cases from the JWD we examined were, for the most part, immigrant and Jewish families. The REI patients were more diverse, split between Catholic and Protestant, about half born in Canada, and two-thirds single. In both data sets, half the patients came under care at ages between 20 and 40, comparable to the ages reported for intake at the Hôpital Sacré-Cœur, for patients at the Institut Bruchési, and for citywide deaths from tuberculosis. While the Jewish community had a lower rate of tuberculosis than in the population at large, it attacked the problem with relatively greater energy, in part owing to the cultural tradition of promoting both charity and self-help.

To meet the specific needs of tuberculosis patients, who were dealing with an evolving disease, a great variety of symptoms, pressures on the family, and dwindling resources, the institutions themselves had to exchange information and achieve a high degree of collaboration. The 51 institutions identified in the 96 X-files (Figure 2) reached across denominations: one-third were Jewish organizations, one-third were Protestant charities, eight were Catholic institutions, three were commercial insurance companies, and four were municipal conduits for public assistance. Some specialized in catering to soldiers, individual cultural groups, or employee groups. Notwithstanding the religious segmentation of the network, need often overrode group affiliation, and the JWD served Protestants, French Catholics, Greek Orthodox, and Aboriginal

20 We did not extend the search for cases to Hôpital Sacré-Cœur, which is a large institution on a more remote site (in Cartierville) with a vast catchment. At its original central location, the Institut Bruchési clinic and small hospital of the Sisters of Providence (at Saint-Denis and Sainte-Catherine streets) worked in much the same way and on much the same scale as the Royal Edward, though it operated a succession of subsidiary clinics (one, two, or three days a week) at other locations.

80 Histoire sociale / Social History

Anti-TB League (1951)	Montefiore Hebrew Orphans Home
Arbeiter Ring (1951)	Montreal General Hospital Clinic (1938) 5x
Baron de Hirsch Institute	Montreal General Hospital Ward E (1941)
Bessarabian Hebrew Sick Benefit Society	Mount Sinai Sanatorium
Catholic Incurables Hospital (1932)	Murray Bay (1954)
Children's Memorial Hospital (1931)	Mutual Life
Convalescent Home in Chateauguay	Old People's Home 3x
Erskine United Church	Orphans Home
Federation of Catholic Charities (1951)	Protestant Nursery, Jeanne Mance Street (1953)
Grace Dart Hospital 9x	Protestant Hospital for the Insane (Verdun) (1925)
Great Western Life	Quebec Public Charities Act (City) 7x
Hebrew Immigrant Aid Society 2x	Royal Edward Sanatorium (1943)
Hebrew Consumptive Aid Society 3x	Royal Edward Hospital (1952) 8x
Herzl Clinic and Dispensary	Royal Edward Institute (1945) 6x
Home for Incurables 2x	Royal Victoria Hospital 9x
Hotel Dieu Hospital, chest clinic	Ross Memorial Men's Pavillon Ward A (1942)
Independent Hebrew Sick Benefit Society 2x	Ward D (1932)
Jewish Foundation Welfare Department 3x	Russian Polish Society
Jewish Foundation Legal Aid Department 2x	Sacred Heart Hospital (1928) 4x
Jewish National Workers of America, Sick Benefit	Saint-Agathe
Jewish General Hospital (1938) 11x	St Jean de Dieu, mental hospital
Lac Brulé / Bordeaux Hotel	St Luc (1953)
Laurentian Sanatorium (1942)	St Joseph Sanatorium, Rosemont (1956)
Laurentian Fresh Air Camp (1930)	Sun Life
Laurier Clinic (1953) 2x	Unemployment Relief Commission (City) registry
London Life	War Orphans Committee
Meurling Refuge (City) (1928)	Young Men's Hebrew Association
Miss Little's Convalescent Home, Mountain St. (1935)	

Figure 2: Institutions Mentioned in X-Files. Source: Canadian Jewish Congress Archives, MB2, Series B, Box 2, Herzl Dispensary, Medical Cases

peoples. Two examples show that the institutional admissions of tuberculosis sufferers transcended ethnic and religious segmentation. In the first case, even though Dr. Mendel had recommended Max X's admission to the Grace Dart Hospital, a long waiting list there meant that Max entered the Catholic Incurable Hospital.²¹ In the second case, 23-year-old Arthur X was an orphan when he was admitted to the Mount Sinai Sanatorium. After a lengthy hospitalization of 414 days, plans for his discharge were initiated, but Arthur's sister and aunt refused to look after him. Without money or a place to go, Arthur was eventually shunted to the Federation of Catholic Charities for placement.²² Such interactions

21 CJCCCNA, MB2, Series B, Box 2, Herzl Dispensary, *Medical Case Files, Including MSS Patients, 1930c–1958*, F1007.

22 CJCCCNA, MB2, Series B, Box 2, Herzl Dispensary, *Medical Case Files, Including MSS Patients, 1930c–1958*, F10169.

bring into focus the important and pervasive problem of integration among the agents of a segmented network and the ways in which a family under stress had to deal with a compartmentalized and increasingly bureaucratized system.

While the 300 cases contain too few families from the large group of French Canadian patients, the array does cover the ethnic diversity and the great range of living conditions among the “popular half” of Montrealers over the years of the Depression, the Second World War, and the immediate postwar period. As we attempt to present a patient-centred perspective, we are less concerned with representativity than we are with two other possible sources of bias. The first, mentioned at the outset, is the filter of social workers who compiled the records and who were inevitably at risk of developing some degree of antipathy toward individuals who did not cooperate. Secondly, even though we adopt an individualist perspective, we understand the need for caution in suggesting the exercise of individual agency.²³ In the social service world of Montreal half a century ago, most individuals were situated in a family, the family in an ethnic community, and the ethnic community in an urban society. The actions, feelings, and will of the individual did affect his or her own health and the outcome of the disease, but those needs and values were rooted in family and community structures shaped by many other vigorous agents. Resources from the larger community were channelled through the families situated in segmented ethnic structures. In their attempts to husband scarce resources, the institutional agents of the community saw the family as the responsible agent.

Case files are rich in descriptions of medical interventions that highlight the progression of diagnosis, treatment, and professional attitudes. The interwar years witnessed a reinvigorated anti-tuberculosis campaign as Canadians optimistically embraced belief in the right of all citizens to good health and in science as the means to solve social problems. The hospitals (Royal Victoria and Sacré-Cœur) and sanatoria (Mount Sinai and Laurentian) were increasing the rate of surgical intervention as treatment for tuberculosis. Norman Bethune, head of the surgical team at Sacré-Cœur, argued in 1937 that any self-respecting institution should have at least half its patients under pneumothorax and that more radical surgery should become more common for advanced cases. In fact, none of the institutions approached such a level, and annual reports show that even at Sacré-Cœur every year more than half of the patients were dying.

23 On this vexing problem, see, for example, Peter King, “Social Inequality, Identity and the Labouring Poor in Eighteenth-century England” in Henry French and Jonathan Barry, eds., *Identity and Agency in England, 1500–1800* (New York: Palgrave, 2004), pp. 60–86; Thomas W. Gallant, “Agency, Structure, and Explanation in Social History: The Case of the Foundling Home on Kephallewnia, Greece, during the 1830s,” *Social Science History*, vol. 15, no. 4 (1991), pp. 479–508.

Before 1950, “progress” came largely from the use of more rigorous tools for diagnosis and monitoring of cases by way of X-ray and bacteriology. Most of the cases initiated at the MCI in 1951 (the later series) were discovered through X-rays performed at one of 17 different locations, usually a consequence of hospital or workplace screening programmes. Greater effort was also made in weighing school children (Montreal was the first city in Canada to initiate school health inspections) to identify vulnerable children and extend access to nourishment and fresh air camps.

The Ideal Patient and the Ideal City

The infectious agent *Mycobacterium tuberculosis* was identified in 1882, and popular understanding of contagion was boosted by experience with the Spanish flu in 1918–1919.²⁴ Under certain conditions, a single person could start an epidemic, and the onus was placed on the individual to prevent it. “TB religion,” a term coined by historian Nancy Tomes, refers to an ideology that required individuals to subscribe to a set of rules aimed at curbing contagion. Centred on the infectious human body were concentric circles of potential contagion — the home, the school-room, public places, buildings such as movie houses, and city streets — in which each sphere contained particular dangers and required specific hygienic precautions.²⁵ Tramway passengers, for example, were seen by public health officials as ambulating sources of contagion. A February 1918 edition of the municipal *Bulletin d'hygiène* denounced the behaviour of a traveller who coughed without covering his mouth, spreading tuberculosis to unsuspecting passengers;²⁶ the same concern was expressed in a

24 Deaths from influenza in 1919 amounted to about half of those from tuberculosis. Awareness of contagion was reinforced in Montreal by recurrences of typhoid, notably in 1927 and 1933, by the anxiety evoked by unwitting carriers like the legendary “Typhoid Mary,” and by unexplained epidemics of poliomyelitis, notably in 1916, 1931, and 1946. On the history of public health in Montreal, see Denis Goulet and Othmar Keel, “Généalogie des représentations et attitudes face aux épidémies au Québec, 1886–1986,” *Anthropologie et Sociétés*, no. 15 (1991), pp. 105–228; Denis Goulet, “Des bureaux d'hygiène municipaux aux unités sanitaires, le Conseil d'hygiène de la province de Québec et la structuration d'un système de santé publique 1886–1926,” *Revue d'histoire de l'Amérique française*, vol. 49, no. 4 (Spring 1996), pp. 491–520; Denis Goulet and André Paradis, *Trois siècles d'histoire médicale au Québec* (Montréal: VLB Éditeur, 1992); François Guérard, “L'hygiène publique au Québec de 1887 à 1939 : centralisation, normalisation et médicalisation,” *Recherches sociographiques*, vol. 37, no. 2 (1996), pp. 203–227; François Guérard, “L'État, l'Église et la santé au Québec de 1887 à 1939,” *Cahiers d'histoire*, vol. 17, no. 1–2 (1997), pp. 76–94, and “La formation des grands appareils sanitaires, 1800–1945” in Normand Séguin, ed., *L'Institution médicale. Atlas historique du Québec* (Sainte-Foy: Presses de l'Université Laval, 1998), pp. 75–91; Georges Desrosiers, Benoît Gaumer, and Othmar Keel, *Vers un système de santé publique au Québec. Histoire des unités sanitaires de comtés: 1926–1975* (Montreal: Presses de l'Université de Montréal, 1991).

25 Nancy Tomes, “Moralizing the Microbe” in Allan M. Brandt and Paul Rozin, eds., *Morality and Health* (New York: Routledge, 1997), p. 272.

26 “Congestion in the Tramways,” *Bulletin d'hygiène*, vol. 4, no. 2 (February 1918), p. 11.

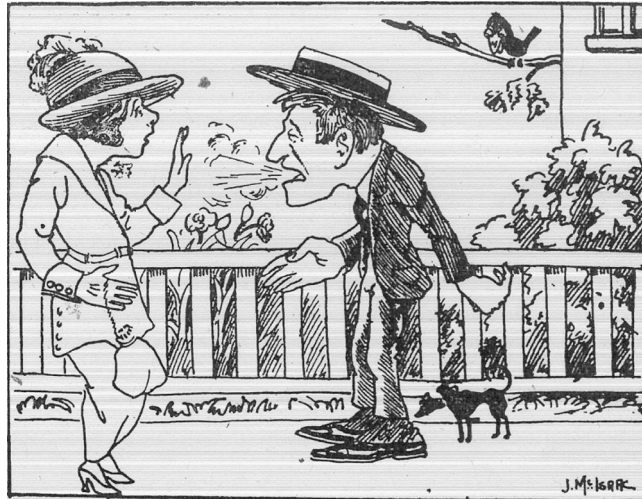


Figure 3: The cartoon was entitled “Les tuberculeux crachent la mort.” The caption argued that the disease was spread mainly by spitting and urged, “Use your handkerchief when you cough.” Source: Institut Bruchési, Rapport annuel, 1919–1920, p. 23.

promotional postcard distributed by the Institut Bruchési in 1922, displayed in Figure 3. Observance of the rules was critical since consumptives did not always show outward symptoms until the disease had reached an advanced stage. Seeking prompt treatment at the earliest sign of disease was therefore a behaviour that demonstrated social responsibility.

To combat the bacillus, the ideal patient was expected to adopt wholeheartedly a health regimen that included isolation, rest, sunlight, fresh air, and nutritious meals: “the most important factor by way of treatment, from a medical point of view of the active case of pulmonary tuberculosis is rest, *rest*, and MORE REST, in the open fresh air as much as is possible, and supplemented by nourishing food in plentiful but not excessive amounts.”²⁷ Bed rest for three to six months, at the heart of the regime, was recognized as a “long and tedious treatment.”²⁸ By the 1930s, collapse therapies such as pneumothorax and thoracoplasty (the surgical removal of one or more ribs) were employed to deflate the infected lung. These invasive surgical interventions were conceived as strategies for resting the lung. Even with the discovery of streptomycin in 1943 (followed by

27 L. C. Fallis, “Treatment of Pulmonary Tuberculosis: Common Symptoms and a Few of the Important Measures,” *The Canadian Nurse*, vol. 24, no. 11 (November 1928), p. 597. See also Institut Bruchési, *Annual Report*, 1920–1922.

28 The Victorian Order of Nurses (Montreal Branch), *Fourteenth Annual Report* (Montreal: John Lovell & Son, Limited, 1912), p. 16.

that of para-amino-salicylic acid and isonicotinic hydrazide, also known as isoniazid), rest was still considered an essential adjunct to drug therapy.

Scrupulous cleanliness was also part of the prescription. The home had to be clean, tidy, and dust-free, and the walls washed down with disinfectants; the services of a charwoman were highly valued. Bed linen and towels used by the consumptive had to be separated from those of other family members. The prescriptions employed in Montreal were drawn directly from operating procedures at dispensaries in New York City, Chicago, and Paris.²⁹ The patient was expected to follow them meticulously and for as long as necessary.

Anti-tuberculosis organizations and health-care facilities marshalled support groups, the most important one being the visiting nurses who specialized in tuberculosis cases and worked out of the dispensaries. In 1939, nurses at the REI distributed 20,000 spitting cups, and the nurses of the Institut Bruchési distributed over 82,000 meals. In 1950, the Institut Bruchési reported 7,000 nursing visits, the REI 11,000.³⁰ In addition to material assistance, the visiting nurses provided health teaching, physical care, and emotional support to patients and their families. Like Gertrude Laporte, a visiting nurse of the Hôpital Sacré-Cœur in 1947 (whose medical bag is contained in the Canadian Nursing Collection at the Canadian Museum of Civilization), the nurses — often middle-class and unmarried — established complex relations with their working-class patients, advising them on an array of subjects, including food preparation, sanitation, and disease prevention. The gap between ideal care and the reality of patients' circumstances sometimes resulted in tensions and conflicts.³¹ The Sisters of Providence commented on the need to “inoculate them [the patients] with perseverance and

29 Benjamin Goldberg, *Procedures in Tuberculosis Control for the Dispensary, Home and Sanatorium* (Philadelphia: F. A. Davis, 1933), p. 163.

30 *Rapport général de l'Institut Bruchési de Montréal, 1935–1943; Royal Edward Institute 30th Annual Report* (1939), p. 13; Ville de Montréal, Département de Santé, *Rapport Annuel pour l'année 1950*, p. 101.

31 A growing literature on the history of nursing that examines these complex relations between nurses, patients, doctors, and community includes, among others, Yolande Cohen, “Rapports de genre, de classe et d'éthnicité : l'histoire des infirmières au Québec,” *CBMH*, vol. 21, no. 2 (2004), pp. 387–409; Nicole Rousseau and Johanne Daigle, “Medical Service to Settlers: The Gestation and Establishment of a Nursing Service in Quebec, 1932–1943,” *Nursing History Review*, no. 8 (2000), pp. 95–116; Jessica M. Robbins, “Class Struggles in the Tubercular World: Nurses, Patients, and Physicians, 1903–1915,” *Bulletin of the History of Medicine*, vol. 71, no. 3 (1997), pp. 412–434; Emily K. Abel, “Medicine and Morality: The Health Care Program of the New York Charity Organization Society,” *Social Service Review*, vol. 71, no. 4 (1997), pp. 634–651; Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990* (Toronto: Oxford University Press, 1996); Baillargeon, “Les rapports médecins-infirmières”; Yolande Cohen and Michèle Gélinas, “Les infirmières hygiénistes de la ville de Montréal : du service privé au service civique,” *Histoire sociale/ Social History*, vol. 22, no. 44 (November 1989), pp. 219–246.

confidence.”³² Patients needed convincing that a home treatment plan would bring about a cure; their families and friends required reassurance that it would reduce their risk of infection. The VON noted, “They pursue the treatment, a hard one at best, at home too with difficulty, often in the face of the opposition of friends and relatives.”³³ It mandated that those attending health classes at the Emmanuel Church, at St George’s Church, and later at the Royal Edward Institute promise to obey health rules.³⁴

The genuine success stories were with “incipient” cases, vulnerable individuals, “demineralized” children, and underweight factory girls who did not show clinical signs of active disease. To restore children to health at the Preventorium at Belœil, “The eggs, the butter, the milk and cream are always on the table.”³⁵ An important expansion of fresh-air camps occurred during the 1930s and 1940s, extending the two-week holidays offered circa 1900 to six- and eight-week therapeutic stays in the Laurentians or at Les Grèves, sponsored by the Sulpician priests. Children fed on bacon and oatmeal at three cents a day and gained 14 pounds in six weeks. The number of Montrealers accommodated at these camps each summer reached 300 in 1931 and doubled in the following decade.³⁶

The ideal location for treatment was essentially rural, and people who had been exposed to tuberculosis or who were ill-nourished, as well as those diagnosed with active TB disease or “the shadow on the lung,” were all urged to leave the city for the countryside, to country boarding houses, hotels, and sanatoria. While most Montrealers could not and did not leave the city, the rural model was important because it framed the prescriptions applied to thousands of city patients and constituted a model for adapting the city itself.

The rural option was considered by each of the patients in the X-files, and Sainte-Agathe-des-Monts, a Laurentian village that boasted “air like champagne,” exemplifies the range of opportunities.³⁷ The town grew in symbiosis with Montreal and was a setting familiar to nine out of ten of our sample cases. From the late nineteenth century, consumptive Montrealers and their families travelled the 85 kilometres to Sainte-Agathe by train. At an altitude comparable to that of Saranac Lake in

32 Institut Bruchési, 2^e *Rapport annuel*, 1912–1915, p. 7.

33 The Victorian Order of Nurses (Montreal Branch), *Thirteenth Annual Report* (Montreal, 1910), p. 12.

34 The Victorian Order of Nurses (Montreal Branch), *Eleventh Annual Report* (Montreal: John Lovell & Son, Limited, 1909), p. 12; see also The Victorian Order of Nurses (Montreal Branch), *Fourteenth Annual Report*, p. 14.

35 Institut Bruchési, *Rapport annuel*, February 27, 1911 to February 19, 1912, p. 23.

36 Institut Bruchési, *Rapport annuel*, 1922–1925, 1925–1926, 1927–1928, 1929–1931, 1933, 1935–1942.

37 Elizabeth Wand, *Quisisana, Ste. Agathe des Monts, P.Q.* (1900), p. 8.

New York State (500 metres), its bucolic setting provided a dramatic contrast to the urban environment that seemed to be making its residents ill. Sites were chosen at Sainte-Agathe for two major sanatoria: the Laurentian in 1908 and the Mount Sinai in 1909. In each case, the clientele was drawn largely from Montreal. The Laurentian Sanatorium, modelled after the Trudeau Sanatorium at Saranac Lake, offered a home-like setting, designed for paying patients. D. L. McGibbon, a paper and rubber entrepreneur who had been treated for tuberculosis at Saranac Lake, contributed two-thirds of the funds for its construction. What started as an eight-bed facility in 1908 became a 45-bed structure in 1911, was expanded to five “country-style” cottages by 1919,³⁸ and in 1941 saw the addition of a 150-bed infirmary alongside the pavilions. In the late 1930s, more than half of its patients were indigents occupying city-subsidized beds,³⁹ and the average stay was 524 days for men and 491 days for women.⁴⁰

Mount Sinai Sanatorium, created on the initiative of tobacco baron Sir Mortimer Davis, was the only Jewish sanatorium in Canada. It claimed to offer hospitalization entirely free of charge to those who could not pay, an expression of the *mitzvah* of *tsedakah* (the good deed of charity and righteousness), which enjoined the community to take responsibility for the well-being of all of its members. Its annual reports describe the institution as a sanatorium “for the free treatment of consumptives.” Despite this, the X-files reveal that social workers of the JWD doggedly appraised the ability of families to contribute to hospital costs; they sought out, interviewed, and cajoled siblings, children, parents, and more distant relatives. While Mount Sinai accepted individuals from all religions and origins, it targeted working-class patients referred from the Herzl Dispensary, mostly Jewish adults and some children: between 1918 and 1947, its staff treated 93 school-age children from Montreal.⁴¹ Non-paying patients were admitted to large wards where they received communal-style nursing and medical care. Mindful both of financial solvency and of community self-sufficiency, the institution grew its own vegetables and grain and, to ensure a kosher diet, managed its own dairy herd, chicken coop, and dovecot.

38 In 1917 the Canadian Military Hospitals Commission took over the Laurentide Inn and opened it as a temporary sanatorium to treat consumptive soldiers until arrangements could be made to admit them to the Laurentian Sanatorium.

39 Royal Edward Institute, *Annual Report for 1938*, p. 9.

40 Laurentian Sanatorium Association, *14th Annual Report* (1939), p. 14.

41 On the extreme shortage of facilities for children, see Rita Desjardins, “L’institutionnalisation de la pédiatrie en milieu franco-montréalais 1880–1980” (PhD dissertation [Histoire], Université de Montréal, 1998); on public health measures targeting children, see Mary Anne Poutanen, “Containing and Preventing Contagious Disease: Montreal’s Protestant School Board and Tuberculosis, 1900–1947,” *CBMH*, vol. 32, no. 2 (2006), pp. 401–428.

The environmental advantages of Sainte-Agathe were not lost on town fathers and local entrepreneurs, who promoted preventive stays as well as curative facilities. Their advertisements echoed the recommendations of professionals and targeted Montrealers of all social classes and ethnicities. Sainte-Agathe offered a mix of recreational sites, boarding houses with verandas, hotels, and restaurants, some of them kosher. Development of a local health-care economy was further promoted by the do-it-yourself strategies of lower- and middle-class families. Nearby Sainte-Sophie and New Glasgow (Saint-Lin or Ville des Laurentides) became sites for working-class Jewish health colonies and summer camps of several religious denominations.

The opening of health-care facilities in rural areas paralleled public efforts to facilitate personal travel and give easier access to vacation homes and other places for family outings, fitness activities, and enjoyment of greenery and country air. The advent of the steam locomotive, of the electric streetcar, and of the internal combustion engine each in turn provoked a dramatic dispersion of activities.⁴² In the real estate boom of 1910, suburban lots were advertised as offering sunlight, fresh air, and good health, and in the 1920s builders promoted porch-fronts and duplex and single-family homes, stimulating the demand for suburban living that would become available to large numbers only in the 1960s.⁴³

The market appeal of suburban living was grounded in a longstanding negative image of the city. The perceived link between crowding and disease had been established long before tuberculosis attained public visibility,⁴⁴ but it became especially important to urban planning under the influence of the anti-tuberculosis movement. In 1910, Lawrence Veiller, a leading housing reformer in the United States, was using medical metaphors to articulate the link between public health and urban planning:

We know . . . that poverty too is a germ disease, contagious at times, that it thrives amid the same conditions as those under which the germs of

42 Joel A. Tarr, "From City to Suburb: The 'Moral' Influence of Transportation Technology" in J. Tarr, ed., *The Search for the Ultimate Sink: Urban Pollution in Historical Perspective* (Akron, OH: University of Akron Press, 1996), pp. 305–322; Joel A. Tarr and Gabriel Dupuis, eds., *Technology and the Rise of the Networked City in Europe and America* (Philadelphia: Temple University Press, 1988). For discussion of the Garden State Parkway and New Yorkers' access to Long Island beaches in the 1920s, see Robert A. Caro, *The Power Broker: Robert Moses and the Fall of New York* (New York: Vintage Books, 1974).

43 For local examples, see Michèle Dagenais, "'Returning to nature': Vacation and Life Style in the Montreal Region" in Dieter Schott, Bill Luckin, and Geneviève Massard Guilbaud, eds., *Resources of the City: Contributions to an Environmental History of Modern Europe* (Aldershot, UK: Ashgate, 2005), pp. 63–79.

44 See Friedrich Engels, *The Condition of the Working Class in England* (Harmondsworth, UK: Penguin Books, 1987 [1845]); Jon A. Peterson, "The Impact of Sanitary Reform upon American Urban Planning," *Journal of Social History*, no. 13 (Fall 1973), pp. 84–89.

tuberculosis flourish — in darkness, filth and sordid surroundings; and that when the light has once been let in the first step towards its cure has been taken. Environment leaves its ineffaceable records on the souls, minds and bodies of men, there to be read by all able to understand.⁴⁵

The story of urban reform is better known, and we need only highlight here the way the anti-tuberculosis campaign intensified public attention to overcrowding, lack of sanitation, and other evils of the “tenement-house system.”⁴⁶

Understandably, New York City and Chicago were leaders in new legislation to prevent overcrowding. New York’s first tenement house law (1867) prescribed minima for room size, window area, and distance between buildings on the same lot.⁴⁷ More surprising perhaps is the degree to which this model was adopted in smaller, lower-density cities like Toronto or Montreal, where there were no “dumbbell tenements” and no working-class neighbourhoods made up of structures over three stories in height.⁴⁸ As Canada’s industrial powerhouse, Montreal had a high proportion of low-wage industries and a reputation for low taxes and low rents. In his classic study of working-class housing conditions, businessman-reformer H. B. Ames pointed in 1897 to “hovels” that should be condemned as unfit for habitation,⁴⁹ but he acknowledged that overcrowding was rare: “Judged by old-world standards, Montreal is not a densely populated city.”⁵⁰ The city’s first comprehensive building by-law (1901) contained regulations for tenements (defined as houses with two or more families) with respect to the building’s position on the lot, minimum ceiling height, and the presence of a window in each living or sleeping room. In addition, new streets were to be laid out at least 66 feet wide.⁵¹ At the same time, rear-of-the-lot dwellings were slowly

45 Lawrence Veiller, *Housing Reform: A Hand-Book for Practical Use in American Cities* (New York: Russell Sage Foundation, 1910), p. 5.

46 Robert Hunter, *Tenement Conditions in Chicago* (Chicago: City Homes Association, 1901), p. 152. See also New York City Board of Estimate and Apportionment, *Final Report of the Commission on Building Districts and Restrictions to the Committee on the City Plan* (1916), pp. 107–108.

47 Standards were low (for example, one water closet for 20 people) and were applied in a lax manner, but their very existence demonstrates the public’s concern and authorities’ willingness to respond. Raphaël Fischler, “Linking Planning Theory and History: The Case of Development Control,” *Journal of Planning Education and Research*, vol. 19, no. 3 (2000), pp. 233–241.

48 In the 1880s, Toronto adopted standards for light and air in new construction, width of streets, open space to be left on each lot, and minimum cubic space per child in public institutions, while Montreal was preoccupied with ensuring the existence of indoor plumbing. Raphaël Fischler, “Development Control in Toronto in the Nineteenth Century,” *Urban History Review*, vol. 36, no. 1 (Fall 2007), pp. 16–31.

49 Herbert B. Ames, *The City Below the Hill* (Toronto: University of Toronto Press, 1972 [1903]), p. 45.

50 *Ibid.*, pp. 58–59.

51 By-law no. 270, passed in 1901 and amended subsequently, section 13. By 1930 additional by-laws created one-way streets and restricted parking (cf. By-law no. 1093, passed in 1930). For earlier

disappearing from the market.⁵² However, much of the new rental housing was built in speculative suburbs outside Montreal, beyond the reach of new by-laws (some suburbs would later be annexed to the city), while in the city these regulations were not applicable to existing buildings and lacked proper enforcement.⁵³

In 1935, the Montreal Board of Trade and the City Improvement League proposed a “slum clearance” scheme for 2 per cent of Montreal’s housing stock. They explicitly associated these scattered “accretions of moribund real estate” with deaths from consumption: “Tuberculosis, the disease of insanitation and under-nutrition, strikes hardest among the slum dwellers.”⁵⁴ It had been a quarter-century since Dr. Elzéar Pelletier, secretary of the *Bureau provincial d’hygiène*, had referred to some of the poorly constructed homes of Montreal as “hotbeds of tuberculosis.”⁵⁵ New York City had just demolished a “Lung Block” that had already been identified as such at the turn of the century, and the Montreal media published reports of a similar “Lung Block” in Baltimore. Since the earliest exhibitions of the Anti-Tuberculosis League, the public was reported to have been “impressed by the desirability of choosing residences in the suburbs rather than in the congested central districts where the mortality from tuberculosis is highest.”⁵⁶

sanitary and fire regulations, see Montreal, *The By-laws of the City of Montreal, compiled, revised and codified by order of the City Council by Chs. Glackmeyer* (Montreal, 1865).

52 Luc Carey, “Le déclin de la maison de fond de cour à Montréal, 1880–1920,” *Urban History Review*, vol. 31, no. 1 (Fall 2002), p. 19.

53 A leitmotiv in Health Department annual reports is the long delay between announcement of a policy and its implementation. A campaign for diphtheria immunization, for example, was launched in 1928, but did not reach its target of 50,000 people until 1933. An agreement to weigh and measure school children was negotiated in 1920, but scales were not purchased until 1930. See also T. J. Copp, *The Anatomy of Poverty: The Condition of the Working Class in Montreal 1897–1929* (Toronto: McClelland & Stewart, 1974).

54 Montreal Board of Trade and City Improvement League, *A Report on Housing and Slum Clearance for Montreal* (Montreal: Montreal Board of Trade, March 1935), pp. 6, 20. It was not until the 1950s and 1960s (beyond our horizon) that the “slums” identified in the 1935 report would be demolished to make room for public projects such as Autoroute Ville-Marie, Place Radio-Canada, and Habitations Jeanne-Mance; see Susan M. Ruddick, “The Movement for Public Housing in Montreal, 1930–1958” (MA thesis [Geography], McGill University, 1979); André Lortie, ed., *The 60s: Montreal Thinks Big* (Montreal: Canadian Centre for Architecture; Vancouver and Toronto: Douglas & McIntyre, 2004).

55 E. Pelletier, “Our Unhealthy Dwellings,” *Bulletin sanitaire*, vol. 8, no. 1–4 (1908), p. 15. Fear of contagion did not always facilitate the fight against tuberculosis. In 1921, for example, when the town of Notre-Dame-de-Grâce was annexed to Montreal, its “not-in-my-backyard” prohibition against any new “hospitals for the treatment of tuberculosis or consumption” was confirmed in that territory under By-law 752.

56 Royal Edward Institute, *3rd Annual Report for 1911*, refers to the impression made by the display at the Child Welfare Exhibition of a pushpin map of cases over the last eight years. For an account of

Provincial and municipal governments also modelled workplace regulations on those of New York and Paris, but with a considerable lag. As in cities on the east coast of the United States, in the decade before the First World War, demand for control of dust contributed to the rapid transformation of garment manufacture from “sweatshops” in residential buildings to factory-floor “loft” buildings. A Montreal by-law passed in 1930 targeted the manufacture of mattresses, upholstery, and rags.⁵⁷ In the mid-1920s, after 30 years of pressure from the health department, by-laws were adopted to secure windows, air shafts, and easy-to-clean surfaces in dairies, restaurants, and bakeries and to require certificates of health for employees who handled food.⁵⁸ Barber shops were ordered to have a “sufficient number of cuspidors, made of impervious material,” and signs were to be posted, “No spitting allowed except in the cuspidors.”⁵⁹ Yet not until 1941 were public school teachers (all) examined, allowing for the identification of 18 active cases of tuberculosis.⁶⁰

At the same time as municipal authorities were trying to limit the circulation of germs, they were attempting to improve the mobility of people and goods in the city. As streetcars, trucks, and motor cars competed for street space, congestion became the key target of public action in transportation, as well as in housing, land use, and public health. But the goals were contradictory: to limit the spread of germs, some people had to be constrained in their movements. The fight against tuberculosis took place in this field of tension. On the one hand, it was crucial for medical personnel to minimize movement among their patients; on the other, patients

the exhibition, see Valerie Minnett, “Disease and Domesticity on Display: The Montreal Tuberculosis Exhibition, 1908,” *CBMH*, vol. 32, no. 2 (2006), pp. 381–400, and “Inside and Outside: Pathology, Architecture and the Domestic Environment at the Montreal Tuberculosis Exhibition, 1908” (McGill School of Architecture, Master’s Project Report, 2004). On the lung block concept in New York and Baltimore, see Samuel K. Roberts, “Where our Melanotic Citizens Predominate” in Paola Boi, ed., *CrossRoutes, the Meanings of “Race” for the 21st Century* (Piscataway, NJ: Transaction, 2003) or <http://www.yale.edu/afamstudies/Roberts%20paper.pdf>.

57 Under By-law 1089, passed in 1930, garment factories had to be “adequately provided with natural and artificial lighting, . . . properly ventilated by windows, sky-lights, or other contrivances in order to ensure the escape of the air and dust not taken care of by the exhaust fans” (article 17).

58 Under By-law 891, adopted in 1925, a dairy could not be part of a dwelling (article 44) and had to be located at least 20 feet from stables, “not less than one hundred (100) feet from any unsanitary establishment, pig-pen, privy, manure heap or refuse heap of organic origin” (article 34). It had to have windows whose “glass area [was] equal to at least one-tenth (1/10) of the floor area” and which were “not to be obstructed by any building or in any other manner whatsoever” (articles 36 and 37). Ceiling, wall, and floor surfaces had to be smooth and easy to clean (articles 38 and 39). See also Joanne Burgess, “Une pinte d’histoire, portrait de l’industrie laitière urbaine,” *Cap-aux-Diamants*, no. 70 (Fall 2002); Denyse Baillargeon, *Un Québec en mal d’enfants : la médicalisation de la maternité, 1910–1970* (Montréal: Éditions du Remue-ménage, 2004).

59 By-law 1006, adopted in 1926, sections 8 and 9.

60 Institut Bruchési, *Rapport annuel*, 1935–1942.

claimed greater mobility for work, trade, and recreation. To understand this tension, we have to look in detail at two distinct kinds of isolation: confinement at home and removal to a sanatorium 85 kilometres away.

Confinement at Home

Of the 150,000 consumptives who, we estimate, lived (and died) in Montreal over the study period, few were ever hospitalized, and fewer still before the disease was beyond cure. All available hospital beds for tuberculars, including those at Sainte-Agathe, were occupied by “advanced” cases.⁶¹ Even those who anticipated a stay in a sanatorium were often obliged to wait at home for months before a bed became available or before they could mobilize the necessary funds.⁶² For patients with few resources, the option the doctor proposed was confinement to the home, and these individuals lived disproportionately in the city’s smaller and older dwellings. We need therefore to consider three issues: Was the home a satisfactory place to get well? How did families cope with the threat of contagion within the household? And how did they cope with the costs of having a sick person at home? Patients who remained at home incurred a loss of income and so did their caregivers. Following recovery, they were encouraged to look for part-time work or for a job that required less exertion than their former line of employment.

In our sample of files, the social worker’s first recommendation to the patient was often to find a more hygienic lodging in a more wholesome neighbourhood. When Benjamin X required admission to Mount Sinai, the social worker visited his home, where he met Benjamin’s wife Millie and their four children. He considered the features of the apartment to be completely at odds with those required for healing: the dwelling was dark and unsanitary with low ceilings. He urged Millie to find a place that was sunny and airy. Seven years later, however, son Morris would be admitted to the sanatorium for tuberculosis.⁶³

The chief target of the nursing sister, the inspector, and the social worker, as late as the 1940s, was “the dark room” shown in a 1920 postcard with the warning “Chambre noire – nid à tuberculose” (Figure 4). Because the terrace or attached row housing of Montreal was, to a large extent, built on lots 25 feet by 100 feet, problems of lighting and ventilation revolved around the arrangement of rooms in a long, narrow building; the most lucrative layout included a room without daylight, as shown

61 Hôpital Sacré-Cœur (burned and rebuilt much enlarged in 1925), the associated hospital for incurables (about one-third tuberculous), the Grace Dart Home Hospital (Anglican), the Anglican Sisters of St Margaret, the Jewish Home for Incurables, and the Saint Joseph Sanatorium opened in 1949.

62 See, for example, Institut Bruchési, *Rapport annuel*, 1942–1944, p. 27.

63 CJCCCNA, X-file1042.

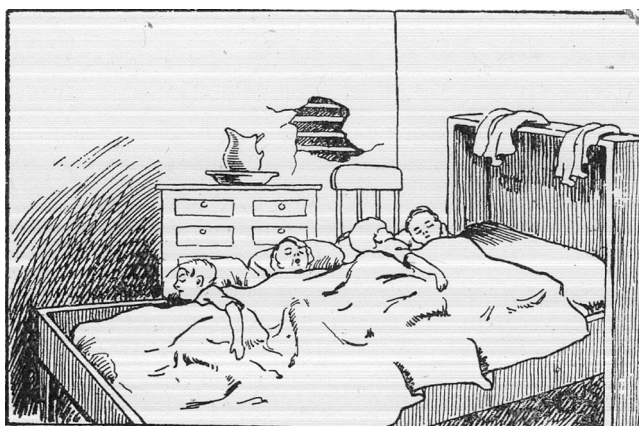


Figure 4: The windowless or shuttered room was targeted as “A Nest for Tuberculosis – Do not rent!” Children deprived of fresh air at night were vulnerable to “a sure means for developing Tuberculosis.” Source: Institut Bruchési, *Rapport annuel*, 1919–1920.

in a plan from the 1935 *Report on Housing* (Figure 5).⁶⁴ Dampness also continued to be a problem. On the other hand, higher standards of building layout and equipment of course meant increased housing costs. By 1942, the 12,000 inside rooms present in Montreal’s housing stock were reported to have been largely eliminated or posted with warning signs, but wartime shortage reintroduced their illegal use as sleeping rooms.

Unusual features of the Montreal housing market were the high proportion of renters (83 per cent of households in 1931) and a one-year lease that created a city-wide game of “musical chairs” on the first of May each year.⁶⁵ The Institut Bruchési attributed half of the drop-outs from its programme to movers.⁶⁶ The very success of the message of contagion aggravated the difficulty of finding a suitable dwelling. Roméo X and his wife were living in a single room in 1943; six weeks later the nurse could not locate them, but 18 months later Roméo reappeared, close to death. “Nurse,” his wife explained, “if you knew how often we have had to move, going from one rooming-house to another. As soon as they noticed my husband was sick, they put us out.”⁶⁷

64 On the description of night air as less polluted, see Goldberg, *Procedures in Tuberculosis Control*, p. 182; Peter C. Baldwin, “How Night Air Became Good Air, 1776–1930,” *Environmental History*, vol. 8, no. 3 (July 2003), pp. 412–429.

65 Marc Choko, “Ethnicity and Home Ownership in Montreal, 1921–51,” *Urban History Review*, vol. 26, no. 2 (1993), pp. 32–41.

66 Institut Bruchési, 2^e *Rapport annuel*, 1912–1915, and *Rapport annuel 1915–1916*.

67 Institut Bruchési, *Rapport annuel 1942–1944*, p. 27.

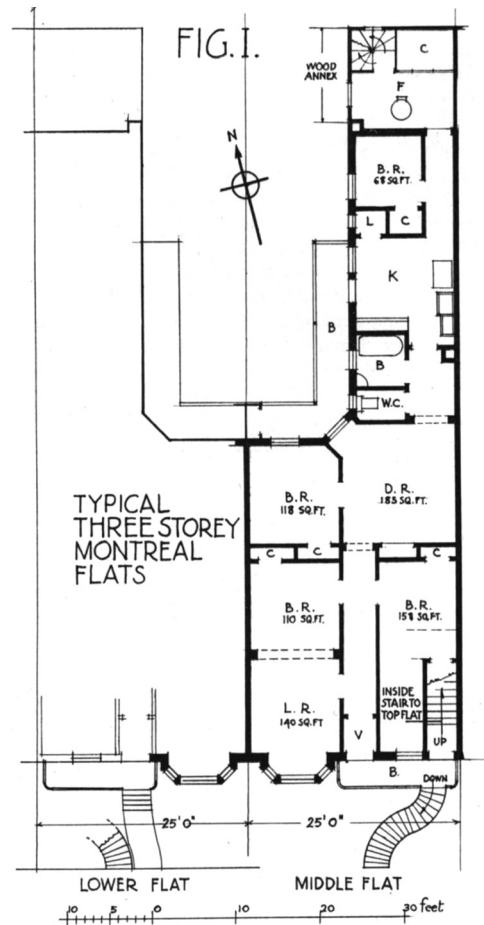


Figure 5: Floor plan of a Montreal triplex, with a family on each floor, shows the windowless interior space of which the use was questioned (BR [bedroom] behind LR [living room]). Source: *A Report on Housing and Slum Clearance for Montreal* by a Joint Committee of the Montreal Board of Trade and the City Improvement League (March 1935), reproduced by courtesy of Concordia University Archives.

Families were urged to adapt their dwellings by using simpler furnishings and smooth finishes. An exhibit of a working-class “re-make” attracted much attention at the Tuberculosis Exhibition of 1908 and again at the 1912 Child Welfare Exhibition.⁶⁸ To maximize exposure to fresh air and ultraviolet rays of sunlight (which would provide helio-therapy

68 Minnett, “Inside and Outside.”

and would help kill germs in the house), the patient should occupy the sunniest, most attractive, and airiest room, with the head of the bed close to an open window. Better yet was removal to the outdoors day and night, on a veranda or roof that would accommodate a bed or *chaise longue*, as shown in Figures 6 and 7. Even in a makeshift space, fresh-air treatment added a significant cost to the household economy: sleeping with an open window in a Montreal winter meant paying more for heat, clothing, blankets, and food.⁶⁹

A second challenge was coping with the threat of contagion within the household. Medical authorities, social workers (whose job included health teaching), family members, and patients all voiced their concerns. Hardest to bear was separation of mothers from their newborns. The Institut Bruchési set up an independent organization to arrange for boarding babies of tubercular mothers. It was practised more effectively in the 1940s and 1950s, when more women were delivering in hospitals and were more likely to be diagnosed.⁷⁰ A physician advised the social worker who was making arrangements to admit Sarah X to Mount Sinai: “She should be forced to enter the sanatorium in light of the fact that she had several small children at home.”⁷¹ Fanny X asked the social worker to expedite her husband’s admission to the sanatorium: “He expectorates all over the house.”⁷² Nineteen-year-old Jeffrey X, discharged from the sanatorium, was living with his grandparents, mother, sister, her husband, and their six-month old baby. Jeffrey “worried because his people do not realize the infectious nature of his illness especially for the baby.” Thirty months later, Jeffrey’s condition had deteriorated to the extent that he received last rites before finally being admitted to the Grace Dart Home.⁷³

Concern led to action, but not without resistance, since strategies of isolation at home could tax family life severely. Authorities told married couples not to sleep in the same bed if one of the partners was ill. Ethel X, confronted by the social worker, responded that she had been sleeping on chairs but found it very uncomfortable, so she slept away from her consumptive husband Daniel “at the foot of the bed.” To correct the situation, arrangements were made for the delivery of a day-bed, but not before Ethel, too, fell victim to tuberculosis.⁷⁴

69 Paul Adolphus Bator, “‘The struggle to raise the lower classes’: Public Health Reform and the Problem of Poverty in Toronto, 1910 to 1921,” *Journal of Canadian Studies*, vol. 14, no. 1 (Spring 1979), p. 45.

70 The Institut Bruchési set up an organization that applied the Grancher method from Paris; cf. the annual report for 1942.

71 CJCCCNA, X-file1003.

72 CJCCCNA, X-file1020.

73 CJCCCNA, X-file 1011.

74 CJCCCNA, X-file1023.

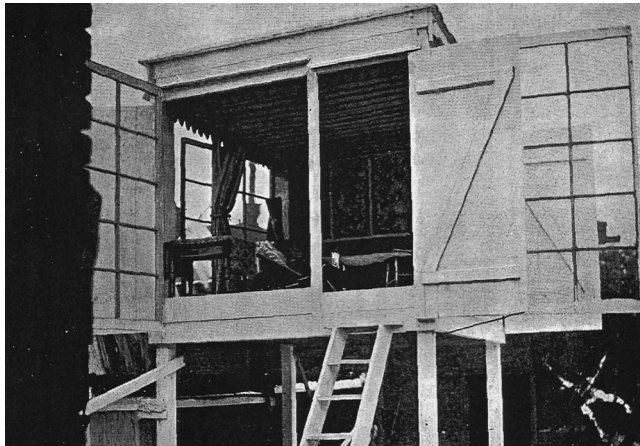


Figure 6: Adaptation to a Montreal row-house porch to allow outdoor rest at home. Source: Royal Edward Institute, Annual Report for 1910–1911, p. 37.



Figure 7: Adaptation to a Montreal dwelling to allow outdoor sleeping. Source: Royal Edward Institute, Annual Report for 1910–1911, p. 51.

The case of seven-year-old Frederick Lear demonstrates the attention that medical personnel could bring to minutiae of daily routine. Frederick ate his supper from separate dishes and cutlery; he was kept isolated from his brothers and sisters and deposited his sputum in special containers. Under the care of the best authorities, he attended the open-air school at the Royal Edward Institute. Frederick recovered and lived well into old age, but his journey to school illustrates the contradiction of mobility. Every day, from his flat in Point St. Charles, Frederick rode the

Wellington streetcar to Place d'Armes, where he transferred to the Guy Beaver Hall car, got off at Belmont (two kilometres in all), and walked the rest of the way to school, carrying his cuspidor with him.⁷⁵ Despite their vulnerability, children were the last served by specialized institutions. In time, a handful of new health institutions catered to children, including the Children's Memorial Hospital, its School for Crippled Children, and the Centre de réadaptation Marie-Enfant, which first opened as a Bacille Calmette-Guérin (BCG) vaccine clinic in 1937.⁷⁶ Children with pulmonary tuberculosis could be admitted to sanatoria that treated TB victims of all age groups. For the vast majority, parents turned to city dispensaries.

A third great challenge was to carry on earning a living. Since the economically vulnerable were also at greater risk, they had to apply ingenuity. Tailors worked at home, setting aside a room from which to carry on the business.⁷⁷ Women whose husbands were ill with tuberculosis used the resources they had available, such as an extra room they could offer to a boarder. Eva X, on capital provided by her son, sold dry goods out of her apartment.⁷⁸ The pressures of earning a living were recognized as the principal source of delay in seeking diagnosis. At the Institut Bruchési, women outnumbered men three to one: "The man is not treated because he cannot take time from work."⁷⁹ Year after year, the number of reported cases was smaller than the number of deaths. An annual report of the institute explains: "Quand l'ouvrier tuberculeux vient, c'est parce qu'il est trop tard, c'est parce qu'il est incapable de faire le moindre travail. L'ouvrier ne peut pas perdre sa journée. Elle représente du pain pour sa famille. Il ne peut pas se ménager." The factory girl, likewise, was "riveted to her job"; any absence made her risk losing it.⁸⁰ For each of the thousand people who died in 1915–1916, the Sisters of Providence estimated the salary lost at one year's earnings (\$500); for each of the ten others whose health was undermined, they

75 Montreal University Health Centre Archives, Fonds Montreal Chest Hospital, Box 8, File 25, Letter to Duncan C. Campbell, President of the Montreal Chest Hospital Foundation from Frederick T. G. Lear, "For Family and the Royal Edward Chest Hospital," November 23, 1990. Frederick's father, who had enlisted at the outbreak of World War I, was in Europe.

76 Hôpital Sainte-Justine did not admit children with contagious diseases until 1932 (Baillargeon, *Naître, vivre, grandir*, pp. 46, 102–104).

77 L. Rosenberg, "How Montreal Jews Earn a Livelihood," *Canadian Jewish Chronicle*, (Montreal), December 27, 1935, and "Montreal Jews in Industry," *Canadian Jewish Chronicle* (Montreal), January 17, 1936.

78 CJCCCNA, X-file1006.

79 "L'homme ne se fait pas soigner, parce qu'il ne peut chômer" (Institut Bruchési, 2^e *Rapport annuel*, 1912–1915, p. 28).

80 Institut Bruchési, *Rapport annuel 1916–1917*, p. 27. "La jeune fille des fabriques est rivée à son travail; elle ne peut s'absenter sans risquer de perdre sa place!"

estimated a loss of \$150. The total annual loss to the economy was \$2 million.⁸¹

Wartime personnel shortages further aggravated delays in treatment. Thirty-eight-year-old Hyman X put off his admission to Mount Sinai in order to complete a mandatory three-week Home Defence Corps training course. In the four months before he appeared at Mount Sinai for treatment, Hyman was presumably working, but his “far advanced” condition on admission and his death in the sanatorium three years later suggests that during that interval he was highly contagious.⁸²

The need to work or the desire to remain active led to conflicts with health authorities. Moe X exasperated social workers, physicians, and family members alike because his manoeuvres to make a living put others at risk. The family first came to the attention of the welfare department in 1925 when doctors recommended that he go to the Laurentian Mountains to recuperate from pleurisy. When plans to send Moe and his wife Gertie to a hotel proved too costly for the Fresh Air Fund, a new strategy was initiated to admit him to the Mount Sinai Sanatorium, but Moe refused to go, opting instead to rent lodgings for himself and Gertie in Sainte-Agathe. When the couple sought financial help from their parents, Moe’s father-in-law referred to him as “lazy and shiftless”; the physicians involved in his care could not agree on what work he could do. One doctor suggested that Moe was healthier than he let on; another recommended sending him to Denver for a change of climate; but the third insisted he remain in Sainte-Agathe. To make a living on his own terms, Moe helped his sister operate a local hotel, set up a confectionary and cigar stand, played the piano at the local movie theatre, gave music lessons, bought a slot machine (eventually confiscated), and established a taxi service between Sainte-Agathe and Montreal. All of these business ventures failed, and the Hebrew Consumptive Aid Society eventually cut off its weekly stipend because of Moe’s proclivity to gamble and to keep lodgers without informing them that he harboured an infectious disease.⁸³ In 1931, we lose track of Moe. His contest with health and welfare authorities, though more persistent than most, illustrates their inability to isolate and immobilize a case of infectious disease.

Remote Confinement

The prospect of treatment far away from home, in a small town in the woods, elicited considerable resistance. Patients moved back and forth, and our object here is to identify the reasons for their mobility and for

81 Institut Bruchési, *Rapport annuel, 1916–1917*, p. 49. The ten-to-one ratio was widely employed; for example, City of Montreal, Department of Health, *Annual Report for 1921*.

82 CJCCNA, X-file1052.

83 CJCCNA, X-file1010.

their resistance to isolation. Patients who had experienced one bout of confinement opposed readmission.⁸⁴ Breadwinners worried about how families would manage without their income, and parents had difficulty leaving their children behind. The length of such a course of treatment was uncertain, and relapse was frequent. Of the 40 MCI out-patient files opened in 1951, 15 reported a previous hospitalization. Of the 96 X-files, one-third referred to a second stay at Mount Sinai or another sanatorium, and the stay varied in length: 34 days (improved), 65 days (expired), 170 days (removed to an institution for incurables), and 417 days (discharged cured), for example. Long stays imposed substantial direct costs and more substantial costs in terms of foregone opportunity or income.⁸⁵

Mothers were especially reluctant to enter hospital. The admission registers of Mount Sinai show that married women were the group most likely to leave before completing treatment. Here, too, individuals expressed or acted out contradictory concerns: fear of infecting their children and anxiety about leaving them in the hands of others. Sarah X, with a far-advanced case of tuberculosis, refused to leave home until arrangements were made for childcare. Although a friend had agreed to take the children during the day while her husband was at work, she insisted that the JWD pay for a live-in housekeeper. When the housekeeper was finally hired, Sarah still refused to leave, claiming that she had no money for the train. She then used the \$2 provided by the JWD to take a taxi to the Royal Victoria Hospital to consult a chest specialist. When the social worker confronted her about the misappropriation of funds, Sarah responded that to go to Sainte-Agathe “was a waste of time and money.” In the face of such recalcitrance and yet initiative, the social worker and doctors agreed that she could stay home: she was looking after herself and had gained eight pounds.⁸⁶

The sanatorium option, in addition to occasioning loss of wages, required outlays for board, nursing, and medical attendance. The Laurentian Sanatorium initially charged \$8 a week for hospitalization, about the average wage of a labourer. The full cost was higher, but the difference was offset by moneys raised through subscriptions and memberships to the Laurentian Society for the Treatment and Control of Tuberculosis.⁸⁷ Indigent patients were admitted beginning in 1925, and the Quebec *Public Charities Act* provided for subsidized beds in several

84 Mary preferred to be hospitalized at Hôpital Sacré-Cœur (CJCCCNA, X-file1028).

85 In the general hospitals, 30 days was an unusually long stay, often associated with typhoid fever or with cases of diphtheria in children at the Alexandra Hospital.

86 CJCCCNA, X-file1003.

87 In 1917 a Free Bed Fund was established to assist “needy persons with the means to take the usual six month treatment at the Sanatorium or to help them to remain their full six months if their means are exhausted.” Montreal Chest Hospital Library, *The Laurentian Society for the Treatment and Control of Tuberculosis 9th Annual Report* (Ste. Agathe des Monts, October 1917), p. 8.

other institutions at \$2 a day (or \$730 per bed per year).⁸⁸ The city negotiated the allocation of those beds.

The cost of maintaining a patient at Mount Sinai was a significant drain on a family budget, a situation to which patients and relatives responded with a variety of coping strategies. The X-files show that the payments were negotiated agreements, sometimes modified over the course of treatment. Issie X, having sold his butcher shop in 1953, agreed to pay \$50 a month for the care of his seriously ill wife, and more should his financial circumstances improve.⁸⁹ One of six daughters agreed to pay a comparable rate (\$12.50 weekly) toward the stay of Max, who suffered from diabetes as well as advanced tuberculosis. (He died two months later.)⁹⁰ Louis, a shoe-store owner, was paying \$40 a week towards his father's care, but in 1933, at the depth of the Depression, he could pay only \$7.50 a week.⁹¹

The cases provide clues to the extent and value of the kinship network as a support system. Polish-born Joe X, a recent immigrant, worked as a waiter in a local delicatessen. When he had to be hospitalized, the JWD contacted its counterpart agency in New York City to see whether his uncle could provide financial aid. The New York social worker visited his aunt, who claimed the family had lost all of their money in the stock market crash of 1929. The social worker reminded her that Joe could be deported back to Poland.⁹²

The ways in which people coped with financial difficulty highlight the importance of mobility. In the search for work, the cycling between odd jobs, and the appeal to a variety of agencies, every new strategy meant moving around and making contacts. Harry X was a carpenter, a trade hard hit by the Depression; he had worked only five months in 1933, labouring at \$12 a week, then took odd jobs at \$8 a week and found himself unemployed for five weeks. His wife, Harry's file also tells us, had \$20 in savings which she kept in a box, owed two months' rent, and had not made the latest payment on their life insurance policy.⁹³ Daniel X was an unemployed presser. He and his wife Ethel spent their nest egg before resorting to handouts from family members, after which they

88 In the provincial system as a whole, the average cost per day to maintain a tuberculosis patient in a sanatorium in 1930 was \$3. Despite provisions for those demonstrably indigent, families were contributing an average of \$93 each, as reported in "Anti-Tubercular Sanatoria," *Annuaire du Québec* (1932), p. 180.

89 CJCCCNA, X-file1001.

90 CJCCCNA, X-file1005.

91 CJCCCNA, X-file1007.

92 CJCCCNA, X-file1058. See also X-file1003 for the far-flung network of Harry and Sarah: they immigrated to Montreal with a young daughter early in the twentieth century; Harry's two brothers and a sister stayed in Poland; his parents and a sister moved to Tel Aviv; another sister married a butcher in Buenos Aires. Sarah had a married sister in Brooklyn as well as a brother and three sisters still in Poland.

93 CJCCCNA, X-file 1003.

borrowed from the United Commercial Loan Syndicate, eventually turning to the Malbish Arumim, a charitable organization that provided clothing to the poor. By the time the JWD became involved, the couple was penniless and unable to purchase Daniel a train ticket to Sainte-Agathe, to buy warm clothing, or to maintain Ethel and the children for the rest of the week. When Daniel was finally hospitalized, Ethel took in a boarder and from time to time asked the JWD to pay part of her rent, a water tax or gas bill, or school fees and books for her children in high school. Ethel herself eventually became ill with tuberculosis, requiring regular follow-up at the Herzl Dispensary and an annual stay at the Laurentian Fresh Air Camp. By then, Daniel had been discharged from Mount Sinai and was operating a cleaning and repair shop in the family's apartment. Their two sons were attending university.⁹⁴ All of these changes in work and housing circumstances, all of these requests, meant movement in urban space and contact with strangers.

Mobility and propinquity were further heightened by the fact that a destitute family had to solicit support from an array of people and institutions. The long association of Ida X and her mother Annie with the JWD reveals some of the difficulties encountered by newcomers. Annie and her two children arrived in Montreal in 1920 from Romania, after a six-month stay in Paris (assisted by Baroness Rothschild) and another six months in Antwerp, where she waited for documents her husband refused to furnish. He had settled in Montreal ten years earlier and had made a new life for himself. On disembarkation she discovered that her husband was living with another woman and had never wanted her to meet him in Canada. He spent eight months in the Bordeaux prison for falsely swearing that she was not his wife, but Annie was never able to collect any support money. To make ends meet, she worked in the clothing trade and lived with an uncle. Her husband eventually became a vagrant; he stayed on occasion at the municipal night refuge and died at a local hospital for the insane. Their daughter Ida was hospitalized for two years at Mount Sinai and, as an unemployed bookkeeper, was readmitted with tuberculosis of the intestine so advanced that she died three months later.⁹⁵ The point here is not solely the human tragedy, but the fact that dealing with complex problems, and the way in which public assistance was organized, demanded frequent and intense interactions with other people and entailed constant movement around the city, in and out of hospital, and from one agency to another.

Even when family support was not at stake, the patient had to move around to obtain appropriate treatment. The variety of manifestations of tuberculosis called for specialized treatments for skin disease, specific

94 CJCCCNA, X-file1023.

95 CJCCCNA, X-file1017.

nursing regimes, and lifetime shelter for the crippled or palliative care. For surgical interventions such as thoracoplasty, patients had to be transferred from Sainte-Agathe to city hospitals and then returned to the sanatorium for monitoring and continued recovery. Before a patient entered Mount Sinai, the family often had to arrange urgent dental treatment, and records show that patients were transported to city hospitals for a range of medical conditions, including diabetes, otitis media, septicaemia, and other lung diseases, as well as renal and cardiac disorders.

Most patients travelled between Montreal and Sainte-Agathe by train. *Le P'tit train du nord* operated daily, carrying Laurentian inhabitants, tourists, sports enthusiasts, and cottagers along with tuberculars and their visitors. The conductor isolated consumptives from other passengers; those transported by stretcher were accommodated in the baggage car. The trip took three hours, starting from Windsor Station at 8:55 in the morning and ending in Sainte-Agathe at noon. Travel by automobile, over a two-lane highway, was much slower.⁹⁶

For a variety of reasons, it was not unusual for an infectious patient to be returned to the city. Mordecai X, deemed “improved,” was released to continue his rest cure at home.⁹⁷ Ernie X, too, was discharged, but because he failed to improve. Since the sanatorium, from the physician’s perspective, was an institution for cure, people such as Ernie, considered incurable, were discharged to die at home.⁹⁸

Others chose to leave the sanatorium against medical advice. As late as 1950, when antibiotics were already part of the treatment protocol, Dr Vineberg of the Mount Sinai Sanatorium argued that patients would do better in the countryside “where there was a minimum of distractions and it was not easy to leave the institution at will for personal reasons.”⁹⁹ Married women could have such “personal reasons”: in addition to being concerned for their children, they were anxious about the fidelity of their husbands. The youthfulness of tuberculosis sufferers and the length of treatment did not bode well for marriage. A consumptive spouse placed enormous pressure on a marriage, and the close-knit “community of strangers” at the sanatorium encouraged romantic liaisons. Taking in a boarder, too, could give rise to a new attachment or to suspicion. Threaded throughout Sholem Shtern’s novel are indications of the value, vulnerability, and destructive potential of romantic attachments. In the story, when Izzy’s wife asks for a divorce, he suspects involvement

96 Joseph Graham recalls a three-hour trip on Route 11, as it was redeveloped in the 1950s. As roads improved, train service declined, ending when the Laurentian Autoroute opened in the 1970s.

97 CJCCNA, X-file1022.

98 CJCCNA, X-file1021.

99 Jewish Public Library Archives, MSS, New Building ‘51-’52 Reports, “Review of facts leading up to the present situation re The Mount Sinai Sanatorium Building Programme,” September 29, 1950, p. 8.

of the male boarder she took in to pay the bills. Jennie and Chaim, patients at the sanatorium, carry on an affair, although Jennie is married and much older than Chaim. Eighteen-year-old Susie and her young paramour both experience a relapse of their tuberculosis after leaving the sanatorium in inclement weather for a lovers' tryst.¹⁰⁰ This aspect of sanatorium life is also addressed in *The Magic Mountain*.

Patients were also sent back to town for breaking the rules. They smoked in restricted areas, imbibed at local taverns in Sainte-Agathe, consumed alcohol on hospital grounds, or covered up for fellow patients.¹⁰¹ Clement X, admitted for advanced bilateral tuberculosis of the lungs, had his stay at Mount Sinai cut short "as a disciplinary measure." Alcoholism seems to have been a factor in his discharge over the previous ten years from three other institutions, the Grace Dart, the Royal Edward Laurentian, and Roberval Sanatorium.¹⁰² Non-compliant behaviour contributed to tensions in the relationships between health practitioners, patients, and relatives. Our sources reflect the social worker's bias against such patients. When 18-year-old Susan X insisted on withdrawing her application to the Laurentian Sanatorium, the social worker interpreted it as a refusal to accept her illness.¹⁰³ The case files speak of insubordination, unruly behaviour, and pregnancy. Such behaviours may in fact have expressed homesickness, financial worries, or youthful exuberance, in addition to what Katherine McCuaig describes as the strain of constantly confronting an institutional culture of enforced boredom, rigid schedules, and the postponement of hopes and ambitions in the constant presence of death.¹⁰⁴ The uncooperative were deemed "difficult" and even seen as trouble-makers. Lithuanian-born Shelley X, unemployed for two months, claimed to social workers that it was impossible for him to pay for his wife's care at Mount Sinai. The social worker, after meeting his previous employer, wrote that Shelley had been fired because he was "a communist causing trouble in the factory."¹⁰⁵

This array of tensions led many tuberculosis patients to a life of compromise, with frequent moves. B, for example, born in Montreal, started work at 11 and held jobs in a variety of trades, including lacquer work on brass.

100 Shtern, *The White House*, pp. 86–91, 140–142, 152–155.

101 In interviews we conducted between October 2003 and August 2005, ex-patients, retired nurses, and managers described the lengths to which patients would go to cover up the drinking practices of fellow patients: distracting nurses during bed counts, hiding a pillow in a bed to create the appearance that it was occupied, and keeping a door unlocked to facilitate re-entry.

102 CJCCNA, X-file1039.

103 CJCCNA, X-file1013; compare with David, X-file1054, who "has accepted having tuberculosis."

104 McCuaig, *The Weariness, the Fever, and the Fret*.

105 CJCCNA, X-file1088. A company spokesman was "certain that he has a bank account as Rose was working as well." Shelley offered an alternative explanation: "he was discharged because his brother left their employ to go into business for himself."

In the 18 years that followed a first bout of pleurisy that he contracted when hunting (in 1929), he made 14 trips to institutions. The first was for a month at Notre-Dame Hospital in the city, the second for a stay at suburban Cartierville (Hôpital Sacré-Cœur). Sent to the sanatorium at Trois-Rivières, he walked out after 15 days and attempted a cure at home for four or five months. When the Bruchési doctors had him re-admitted at Trois-Rivières, he delayed admission for five months in order to work, and then abandoned the course of treatment altogether after six weeks. At Cartierville, he “took the straight cure” for seven months. He began to do some work in the country, but started coughing blood again, so he “cured” for another 17 months in Cartierville. He moved home and back, spending three months in Trois-Rivières, then went home again when his mother fell ill. Now very thin, he went to the Grace Dart Home for three months, tried a place in the country, returned to the Grace Dart for 15 months, and left, only to return for a month in winter. After a summer at home, he spent 18 months in the Laurentian Sanatorium, was moved to Montreal for surgical collapse, and returned to the sanatorium “undernourished, deteriorating, not improved.”¹⁰⁶

Conclusion: The Underlying Contradiction

The fight against tuberculosis raised a set of contradictions in how professionals in medicine and social work dealt with individual and public health. As agents in a segmented system, they were trying to achieve some integration, while families under stress were coping with a differentiated and increasingly bureaucratized structure. Patients were expected to be docile and yet self-sufficient, isolated, and responsive to the demands of various institutions. The plan was to contain contamination by confinement to home or sanatorium, but case files indicate that patients remained highly mobile. Bernie X, to whom we were introduced at the beginning of the article, was discharged from Mount Sinai four days after his friend announced that he could no longer help pay expenses. His readmission three months later suggests that Bernie remained contagious in the interim. Hospitalization did constrain movement, but it occurred long after diagnosis; for the majority of sufferers, like young Frederick, who were dependent on dispensaries, the prescribed programme demanded mobility.

There were few ideal patients, and few perfect protocols of treatment that their families could afford. To a large extent, the lack of isolation and of immobilization was due to a want of resources not only in households but in charitable institutions and in municipal budgets. The ideal cure, ideal in intent but not in outcome, was affordable only to the rich. Year after year, the Catholic and Protestant nursing sisters as well as the

106 Montreal Chest Institute, In-patient 2986.

JWD social workers described the financial hardships of patients and their families. What our patients need in their condition, said the Sisters, is “une existence plus reposée, mieux nourrie, plus facile.”¹⁰⁷ Their observations were consistent with the findings of investigations by the city, which led Montreal to authorize subsidies for 200 or 300 cases per year, relative to the 400 or 500 deaths per year.

The strategy for combating the spread of tuberculosis in Montreal was imperfect, cumbersome, and costly in both financial and human terms, but reasonably coherent. Between 1910 and 1935, all the organizational components were set in place, with adequate mechanisms of coordination; the behavioural, architectural, and medical strictures on which this strategy relied were disseminated among patients, relatives, and professionals. Adherence to the model was never backed with the necessary public financing, however, and a new campaign to expand resources, developed with consensus from many elements of the community in 1928, was hampered by the financial crash a year later, then by the long Depression and the Second World War. The Depression strained the capacity of health-care institutions; the Herzl Dispensary, for example, saw close to 28,000 patient visits in the peak year of 1933.

For most city-dwellers, isolation and immobilization were at odds with their needs and ambitions. Earning a living, attending school, or taking care of the family called for mobility, and, facing the prospect of a long illness, their wish to maintain a normal existence made it hard for them to submit to the dictates of doctors, nurses, and social workers. Most patients continued to share indoor space with family members and boarders and to share public spaces with a multitude of strangers. Visits to numerous agencies and specialized facilities added to the number of trips and the number of encounters. Negative comments sanctioned patients' failure to conform to ideals, bringing humiliation and self-blame to people already suffering from penury, frustration, and anxiety. The fear of contagion arose from the stigma associated with tuberculosis but also added to it.

In the quarter-century prior to the introduction of streptomycin, the modest and steady decline of the numbers of deaths from tuberculosis cannot be attributed to successful treatment. A small but significant proportion of those who died of tuberculosis had received what was presumably the best possible home or institutional care before their illness reached an “advanced” or “terminal” stage. Nineteen of the 96 patients whose disease was reported as “cured, improved, arrested, or quiescent” subsequently relapsed. Nor can the decline in mortality be attributed to success in isolating the diseased. Various other reasons have been proposed to explain it: Was it a consequence of better nutrition? Of the

107 Institut Bruchési, *Annual Report for 1920–1922*, p. 18.

gradual and steady increase of dwelling-space per person? Of the reduction of the “insults” of childhood diseases? Of the substantially improved cleanliness of cities? More effective inspection of milk, dairy herds, and food preparation (achieved in Montreal by 1935) contributed to a reduction in childhood and non-pulmonary cases of disease caused by *Myco-bacterium bovis*, and factory inspection began to have some impact on working conditions in cities. Recent evidence from Paris, for example, suggests that the focus on housing was misplaced, detracting from the problems of poverty, undernourishment, and working conditions that made people vulnerable to tuberculosis.¹⁰⁸

We thus cannot be sure to what extent the ideology of hygiene imposed in our study period (1925–1950) affected either morbidity or mortality, but the ideology, promoted as a response to the threat of tuberculosis, did have an impact on the form of cities, especially as they emerged at the end of the Second World War. The war against tuberculosis gave ideological and practical support to the movements for housing reform and for modern zoning and planning in the 1910s and 1920s. After World War II, at precisely the moment that the “silver bullet” of streptomycin offered an effective cure for tuberculosis, the ideology of light and air, of isolation and confinement, by now well-ingrained, would drive demand for the new car-dependent “suburbia,” informing its planning and design and, conversely, fuelling rejection of older habitats, high-density living, and public transit. A fresh-air regime persisted in the treatment of tuberculosis, and fear of the “lung block” continued to stimulate withdrawal of the middle class from the central city and the collective confinement of the poor in “inner-city” neighbourhoods.

Today, most of the world’s largest cities are experiencing deaths from active tuberculosis disease at rates comparable to those of Montreal in the 1930s and are seeing high rates of infection with latent tuberculosis. They are also experiencing the leap in mobility we have observed here, for example with the construction of subways in São Paulo, Pyongyang, Beijing, and Calcutta. In North American cities, too, opportunistic bacteria (including drug-resistant strains) have taken advantage of the new levels of mobility, in particular mass travel by plane to remote “fresh air” destinations, cross-border movement of refugees, and local movements of homeless and mentally ill individuals who have been “discarded” into the streets. Relative to Canadian cities, rates of active tuberculosis are

108 For an analysis of how the link between housing and health was socially constructed, see Alain Cottureau, “La tuberculose : maladie urbaine ou maladie de l’usure au travail? Critique d’une épidémiologie officielle : le cas de Paris,” *Sociologie du travail*, vol. 20, no. 2 (1978), pp. 192–224; Yaskel Fijalkow, “Territorialisation du risque sanitaire et statistique démographique. Les immeubles tuberculeux de Saint-Gervais,” *Annales de Démographie historique* (1996), pp. 45–60, and *La construction des îlots insalubres, Paris 1850–1945* (Paris: L’Harmattan, 1998).

higher in American cities where the profit orientation of health insurance, first-line care, and hospital care creates large zones of social exclusion.¹⁰⁹

The high value placed on personal mobility, fostered by economic competition, municipal and regional ambition, and professional planning, simultaneously promotes microbial mobility and undermines medical strategies for timely isolation to control disease. As displayed in the Montreal cases of tuberculosis in the 1930s, and as recognized in campaigns for control of HIV since the 1980s, a strong message on the danger of contagion induces flight, evasion, guilt, secrecy, and stigmatization of the vulnerable.¹¹⁰ Today as in the past, scarcity of resources for public action leads rapidly to private strategies of exclusion, leaving sinks of reduced mobility among people with the fewest personal resources. The problem of tuberculosis remains, precisely as the Institut Bruchési defined it in 1922, a problem of social justice: “Créé pour combattre un mal social, dont la cause réside dans la Société, le Dispensaire antituberculeux est un peu le compensateur des torts causés à une portion du peuple par la mauvaise organisation de notre état social. *Pour nous notre devoir a un motif de justice.*”¹¹¹

109 R. G. Barr, A. V. Diez-Roux, C. A. Knirsch, and A. Pablos-Méndez, “Neighborhood Poverty and the Resurgence of Tuberculosis in New York City, 1984–1992,” *American Journal of Public Health*, vol. 91 (2001), pp. 1487–1493; Matthew Gandy and Alimuddin Zumla, “The Resurgence of Disease: Social and Historical Perspectives on the ‘New’ Tuberculosis,” *Social Science & Medicine*, vol. 55 (2002), pp. 385–396.

110 Peter Gould, *The Slow Plague: A Geography of the AIDS Pandemic* (Oxford: Blackwell, 1993); Randy Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York: St. Martin’s Press, 1987); Susan Sontag, *AIDS and its Metaphors* (New York: Farrar, Straus, Giroux, 1989).

111 Institut Bruchési, *Annual Report for 1920–1922*, p. 18.