Penitentiary Practice:
Healthcare and Medicine in Minnesota State Prison, 1855-1930

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF THE UNIVERSITY OF MINNESOTA
BY

Margaret Lynn Charleroy

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

John Eyler, Co-Advisor
Jennifer Gunn, Co-Advisor

November 2013

© Margaret L. Charleroy 2013

Acknowledgements

Susan B. Anthony wrote, "I had rather…make history than write it." Although her activism remains her legacy, we must not forget the scribes who wrote her story. The historian assumes this responsibility, and, no historian is alone in this work. The contributions of archivists, librarians, mentors, and colleagues have guided my research as much as the records themselves. Each has shown me how to be an historian, how to think across disciplines, and how to identify the humanity of the characters I explore.

I collected materials for this project from collections throughout Minnesota and the United States. Thank-you to the archival staff that made this research possible, especially Debbie Miller of the Minnesota History Center, the staff of the National Library of Medicine, Brent Peterson and Sean Pallas of the Washington County Historical Society (MN), and Warden John King at the Minnesota State Prison.

Elaine Challacombe, Jim Curley, and Lois Hendrickson of the Wangensteen Library at the University of Minnesota taught me how to research. Each one patiently worked with me through every part of my graduate career. During my dissertation research I often met with Lois to showcase materials and findings, during which she would identify additional collections to supplement my work. She introduced me to research methods, and materials. If I requested one manuscript from the Wangensteen Collection, Lois would bring numerous volumes and citations that were related to the requested material. And I was giddy with excitement to learn how she identified all of the supplementary materials. When I needed to fill holes in my research I'd think to myself, "What would Lois do?"

I was the recipient of an Interdisciplinary Doctoral Fellowship for the 2009-2010 academic year, where I was hosted by the Minnesota Population Center at the University of Minnesota and mentored by director and professor of history Steve Ruggles. Steve introduced me to methodologies that allowed me to join quantitative and qualitative resources in my pursuit of understanding the morbidity and mortality of prison populations through census and prison data. Steve introduced me to the IPUMS historical data projects, and trained me into historical data collection. I used a significant amount of my fellowship year at the MPC year to collect data from the inmate medical records of Minnesota State Prison into a digital database.

No one understood the dissertation processes better than my fellow graduate students. Thank you to my History of Science, Technology, and Society graduate colleagues Margaret Hofius, Neal Holtan, Peter Kernahan, Cara Kinzelman, and Barbara Louis for their numerous discussions of research, both relevant and irrelevant to the topic at hand. My Minnesota Population Center colleagues encouraged me to employ quantitative methods and weave them into my historical narrative. I was always at home at the Minnesota Population Center, where my colleagues embrace and employ interdisciplinary methodology. Thank you, especially, to Julia Rivera Drew, Catherine

Fitch, Sarah Flood, Katie Genadek, Rachelle Hill, Ellen Manovich, Jose Pacas, Evan Roberts, and the previous keepers of the "Dissertation Dove."

I was introduced to this field in my undergraduate freshman seminar taught by Jim Strick. I was attracted this his coursework in Science, Technology, and Society because, to me, it embodied the true nature of the liberal arts and interdisciplinary studies. I continued to explore these themes through the guidance and research of History of Science, Technology, and Medicine faculty at Minnesota, especially Susan Jones, Jole Shackelford, and Dominique Tobbell. I owe my greatest thanks to my advisors, John Eyler and Jennifer Gunn. I was first inspired by John's work related to medical statistics, which I continued to explore with Steve Ruggles in the Minnesota Population Center. Jennifer served not only as an academic/dissertation advisor, but also as a knitting instructor, a bus companion, and a friend.

Although my writing happened during late nights in front of my computer, much of the reflection occurred in the ring at Uppercut Gym in Minneapolis. Thank you to my sparring partners and fellow trainers, especially Kim Heikkila. It was during my workouts with Kim where we would apply our research methodology objectives to our rounds, true cross-disciplinary learning. I must extend a very special thank you to owner Lisa Bauch, who was always ringside to give me feedback when I was at the gym and reminded me that I sometimes needed to take a break from writing.

Two friends, Sarah Dobkin and Rachel LaForgia, offered support from afar in creative ways. Sarah sees into the material soul of things that others might not value. She sees the artistry in wrapping paper, the simple brilliance of a romance novel, and memory in every ticket stub and performance program. She challenged me to look beyond the surface. And, in doing so, I found my often-discounted prison population. Rachel kept me humble through all of grad school, sometimes by sending packages through the mail with embarrassing pictures of me taped to the outsides, and sometimes by addressing mail to "Margaret Charleroy, ABD" or "Margaret Charleroy, not quite PhD." I have been inspired by Rachel's goodwill and ability to make change in the world since we first met during our freshman year of college. And, her support not only gave me confidence, but also a smile and a much needed laugh.

My family has supported me in every adventure and challenge in my life, large or small, sane or insane. They agonized with me in my defeats, celebrated in my happiest, most successful moments, and learned with me in new pursuits. My mother, Carol Charleroy, shared her love of learning with me during every bedtime story and each "museum day" we took together. My father, Thomas Charleroy, encouraged me to learn by experience and taught me patience in the process. It is also through his experiential learning that I was educated in welding and woodworking at an early age. I tried every day of my childhood to match the deep curiosity and achievement of my older sister, Maureen Charleroy, even though she earned me a permanent seat in the front row of 8th grade Spanish because of her talkative nature in class five years earlier.

In the early stages of my dissertation research I met Joe Martin, a fellow graduate student, at the Wangensteen Biomedical Rare Books Library at the University of Minnesota. Upon first meeting we talked about creating a hockey team for the US National Pond Hockey Championships, and we became instant teammates both on and off the ice. I could not have completed the end stages of this project without Joe on my team. And without this project, I would not have my now husband Joe as my teammate. Thank you.

Dedication

For my mother,
  Who read to me.

For my father,
  Who taught me history.

For my sister,
  Who walked me to school.

Abstract

Medicine in American prisons came to be defined by a characteristic set of health concerns and treatment challenges through the late nineteenth and early twentieth centuries. Foremost among them was the essential tension between the prison's retributive, disciplinary, or reformatory objectives and the ideals of care at the core of medical practice. This dissertation examines the history of the American prison and its population by considering the prison as a medically therapeutic and rehabilitative institution constrained by its punitive mission, using the Minnesota State Prison at Stillwater as a primary case study. It situates the prison within a historiography of medical institutions that has heretofore focused on hospitals and asylums.

Quantitative data and methods help to expose the demographic characteristics of the prison population between1850 and 1930. Using historical census data and institutional medical records, I build this contrast to show how population-level characteristics shaped medical practice in American prisons. Additionally, I employ statistical methods to analyze quantitative material available in the state archives of Minnesota to contextualize the stories of individual prisons and prisoners. These qualitative and quantitative data sustain a historical narrative and a sociological depiction of the prison as a medical institution.

Table of Contents

Acknowledgements .... **i**

Dedication .... **iv**

Abstract .... **v**

List of Tables .... **viii**

List of Figures .... **ix**

Introduction: Care and Confinement **1**
- Introduction 1
- Argument 2
- Statement of Methods and Sources 5
- Historiography 7
- Outline 14

Chapter 1: The Principles and Practices of Penal Reform **19**
- Introduction 19
- History of the Prison in America 25
- The Minnesota State Prison at Stillwater, a History 35
- Conclusion 53

Chapter 2: Making Medicine: The Role, Duty, and Difficulties of the Prison Physician **56**
- Introduction 56
- Medicine in Nineteenth-Century America 59
- Physical Constraints of Medical Practice at Minnesota State Prison 65
- Population Focused Practice of Medicine at Minnesota State Practice 71
- Dual Responsibilities of the Prison Physician at Minnesota State Prison 79
- National Study of Health and Medicine in American Prisons 93
- Conclusion 99

Chapter 3: Prisons, Health, and Hygiene: Health and Disease Demographics of Late-Nineteenth-Century American Prisoners, 1880-1920 .... **102**
- Introduction 102
- Methods & Materials 104
- Inmate Demographics 108
- Conclusions 125

Chapter 4: Policing the Mind: Phrenology, Psychology, and the Era of the Curable Criminal, ca. 1890-1920 .... **127**
- Introduction 127
- Phrenological Theories of Crime and Criminality 130
- Phrenology in the American Prison 136
- The Rise of Psychology in the American Prison 143
- Psychology and the Treatment of Criminality in American Prisons 147
- Conclusion 153

Chapter 5: The Decline of the Rehabilitative Ideal: The Rise of the Criminal Asylum, 1875–1920 .... **156**
- Introduction 156
- Literature Review and Context: The Asylum in America 158

Institutional Population of the Turn-of-the-Century United States 168
The Birth of the Asylum in Minnesota 178
Conclusion 185

Conclusion: The Prison as a House of Care 188

Bibliography 192
Secondary Sources 192
Primary Sources 204
Archival Sources 219

Appendix A. Detailed disease classification by researcher-imposed grouping. 221

Appendix B. Chart of relevant staff at Minnesota State Prison, 1860-1920. 223

Appendix C. Duties of the Prison Physician of the Minnesota State Prison, Stillwater, Minnesota. 227

Appendix D. Duties of the Warden of the Minnesota State Prison, Stillwater, Minnesota. 230

Appendix E. Duties of the Deputy Warden of the Minnesota State Prison, Stillwater, Minnesota. 232

Appendix F. Duties of the Prison Chaplains of the Minnesota State Prison, Stillwater, Minnesota. 235

Appendix G. Duties of the Prison Matron of the Minnesota State Prison, Stillwater, Minnesota. 236

Appendix H. Excerpts from general rules for inmates, as depicted in the inmate handbook and re-printed in the annual reports of the prison. 238

Appendix I. Superintendents of St. Peter State Hospital, 1866-1920. 247

List of Tables

Table 1: *Insane population as enumerated in the 1840 decennial US census by state* . . 175

Table 2: *Number and rate of insane individuals in US population by census year* 176

Table 3: *Institutional Population of Minnesota, 1910* 177

Table 4: *Average Annual Institutional Population of St. Peter State Asylum, 1875-1910* 178

List of Figures

Figure 1: Aerial depiction of Haviland's radial design at Eastern State Penitentiary, 1855. 28

Figure 2: Ground plan of the new site of the Minnesota State Prison at Stillwater, 1909. Opened 1912. 50

Figure 3. Inmate medical intake form from Minnesota State Prison, 1903. 74

Figure 4. 1903 Bertillon report from inmate medical file at Minnesota State Prison...... 75

Figure 5: Three classes of prison uniforms at Minnesota State Prison at Stillwater, grade three to one (left to right), photographed 1905. 81

Figure 6: Number of Inmates at Minnesota State Prison by Year, 1860-1930. 110

Figure 7: Incarceration rates in the United States and the State of Minnesota, 1850-1930. 111

Figure 8: Frequency of inmate disease diagnosis by the prison physician at Minnesota State Prison, 1870-1920. 112

Figure 9: Reported sickness of the general public, reported in the US Census, and of the inmate population of Minnesota. 114

Introduction:
Care and Confinement

A Prison is a house of care,
A place where none can thrive,
A touchstone true to try a friend,
A grave for man alive.[1]

Introduction

When a Scottish prisoner scrawled, "A Prison is a house of care/A place where none can thrive" on his cell wall sometime in the mid-nineteenth century he articulated the contradiction many prisoners felt. His words resonated with inmates at Minnesota State Prison at Stillwater, who reprinted them in the first issue of the *Prison Mirror,* an inmate-run newspaper, in 1887. The tension this prisoner felt, as this dissertation argues, was not limited to the experience of prisoners. It was also central to shaping medical practice in American prisons through the late-nineteenth and early-twentieth centuries. The prison at Stillwater is prime example of the challenges in creating a medicine for the prison context, which pursued competing missions to punish and to rehabilitate. The former has received the bulk of the attention, and the understanding of the prison as "a grave for a man alive" is echoed in most histories of the American prison. My story considers how the punitive aspect of prison life existed in both competition and cooperation with the other mission—the therapeutic aspects of the American prison system—and how prison medical practice was guided by this tension.

[1] Inscription from a wall at Edinburgh prison, date unknown. Published in the first edition of the *Prison Mirror*, the inmate-run newspapre at Minnesota State Prison at Stillwater published in 1887.

Argument

Medicine in the prison existed with competing objectives. One on hand, medicine, and those practicing it, aimed to rehabilitate inmates and prepare them to contribute to society upon release. On the other hand, medicine was practiced in a context where the mission was to house, control, and discipline inmates for the actions that brought them to the institution. This conflict can be seen at two levels. First, it manifested at the individual level of those practicing medicine within the prison. Second, it appeared at an institutional level defined largely by the penological mission pursued by prison administrators and legislators. This made medical practice in the prison more innovative, as practitioners, called upon to balance what sometimes seemed like contradictory objectives, were willing and able to experiment with treatments, physical structures, and social organization. In this sense, the prison was a frontier medical practice.

The physician's willingness to deploy novel medical practices was both enabled and defined by the stark differences between prison practice and traditional private practice outside of the prison walls. The physician was pressured by competing objectives in the prison, not just to uphold, simultaneously, the rehabilitation and retributive aspects of the prison mission, but also by economic factors. For example, the Minnesota State Prison at Stillwater was largely financed by the industries that existed on the prison grounds. In that sense, the physician faced pressure to uphold the financial stability of the prison by healing inmates to return to work in the prison workshops. The physician also benefited from robust prison industries, as his budget was dictated by their success and apportioned to him by Minnesota's State Board of Control. This often meant

that the physician was forced to stretch a thin budget, which he supplemented by petitioning the government for additional financial resources to expand medical practice in the prison. At the turn of the twentieth century, the prison physician successfully lobbied the state for resources to pay for a small on-site laboratory, x-ray equipment, and a freestanding hospital in which to care for inmates. The former were luxuries the physician likely could not have secured in a small private practice during the same period.

Input and impact on prison budget is one way in which the prison physician exerted control in the prison. The physician could also influence the physical structure of the prison to advance therapeutic objectives. Physicians often acted as consultants for hospital and asylum projects in the late-nineteenth and early-twentieth-century United States. Their input was used to create a therapeutic environment, often by designing well-ventilated and sunny areas for the sick to convalesce. In the prison, the physician not only influenced the design of the on-site hospital for the sick, but also actively shaped space for the healthy inmates by offering input on cellblock design. The state government and architects solicited the physician's ideas to create cellblocks that prevented rather than fostered the spread of illness, as was common in prisons where inmates were held in close quarters. The physician at Minnesota State Prison advocated window placement to promote cross-ventilation in the cellblocks, and also suggested the cellblocks be east/west facing to allow for maximum exposure to sunlight.

By designing the cellblock to promote health, the physician acted like a contemporary public health physician would have; his concern was the health of the

inmate population as a large-scale entity. At the same time, the physician was responsible for the daily care of individuals. He met and treated individual inmates for a variety of ailments—physical injury, acute disease, chronic disease, and others. His role within this context was defined by being an adept specialist, as he simultaneously acted as a general practitioner, public health physician, infectious disease specialist, and mental health specialist, which at the same time made him an extreme generalist by demonstrating such a wide-set of medical responsibilities in the prison. It was common for a general practitioner to refer patients to other practitioners when outside of his scope of practice. The prison physician often did not have this ability and, instead, had to expand his scope of practice to meet the needs of his inmate patients. The structural constraints imposed by the prison prompted changes in medical practice, helping to craft the contours of a practice fit for a correctional environment.

This is also evident in the physician's role in classifying inmates at the prison. Individuals who were sentenced to prison first encountered the physician upon entry. The physician performed a comprehensive physical exam of all inmates. This assessment determined an inmate's labor placement within the prison. After completion of the physical exam, the physician interviewed each inmate about his medical history, as well as familial medical history. Each inmate was assessed for mental capacity and stability. Those with weak mental health assessments were typically required to meet with the physician for counseling and treatment. Those deemed to possess strong mental capacities were often given more responsibility in the prison, both in terms of labor placement but also in terms of recreation. The physician, in caring for inmates' minds and

bodies, was responsible for the mental health, physical health, and population health of the inmate population of the Minnesota State Prison at Stillwater.

The physician defined a medical practice in the prison to allow for his distinctive and competing objectives, one that forced him to experiment with medical practice to find the right balance of individual versus population health, physical versus mental health, and reformatory versus punitive responsibility. In experimenting with balancing all of these competing objectives, the prison was his laboratory of medical practice. This dissertation develops this theme across five chapters, discussing the place and practice of medicine at Minnesota State Prison at Stillwater between 1850 and 1930.

Statement of Methods and Sources

Medicine in the prison context evolved to balance competing objects. I examine the establishment of a medical practice carefully adapted to the social, physical, and demographic conditions at the Minnesota State Prison at Stillwater at the turn of the twentieth century. Minnesota's prison, established on the basis of penal thinking developed on the East Coast in the early nineteenth century, provides an apt case study for how those philosophies responded to real-world conditions as they were put into practice. This case study therefore offers insight into national trends in American correctional institutions. The records of the prison are among the most comprehensive preserved, offering administrative, medical, inmate, and personnel records. Both quantitative and qualitative materials from the prison provide a basis for examining the health of inmates, their demographic characteristics, and the specialized brand of medical

practice that formed within the prison to maintain their health. Traces of this practice can be found in the writings and records of prison officials, including the warden, physician, state oversight boards, and inmates themselves. I rely on the inmate health records kept by the prison physician to describe day-to-day practice in the prison. The physician managed the placement of inmates in the prison, but also tracked patterns of health and disease among the inmates. These records permit a thorough examination of the health of the prison from a population perspective. Combining an examination of the qualitative aspects of practice through individual patient records with an assessment of the population-level pressures that shaped the physician's approach to his role provides a basis for discussing how the demands of his job at different levels shaped the evolution of prison medicine.

A population-based approach to study the health and disease of prison inmates in the late-nineteenth and early-twentieth-century Untied States relies on quantitative historical methods. This involves aggregating medical records from the prison to examine the health of a population. Generating these quantitative analyses reveals how the prison physician perceived and responded to the characteristics of the population he served, both by highlighting the major challenges he faced, and by indicating where he might have misapprehended large-scale conditions. Quantitative analysis, however, is not my primary or only means of study. The quantitative findings presented here enhance a qualitative narrative about the creation of medicine for the prison context in which traditional medical values had to make space to accommodate the punitive aspects of the prison's institutional objectives.

Historiography

My approach to examining the creation and place of medicine in the prison context touches upon several bodies of literature. I engage with themes from medical history, prison history, and historical demography, and a number of sub-specialties within these fields. Part of the challenge of composing a history of medicine in an institution that is not typically seen as therapeutic is attempting to engage with methods and themes from across these fields of study. In particular, I engage the quantitative methods of historical demography in a way that remains sensitive to a qualitative institutional narrative. Traditional historical demographic studies have examined themes from the history of medicine such as fertility, morbidity, and mortality, but these studies have largely been out of the scope of the traditional medical historiography. Some social medical histories deployed quantitative approaches in the mid- to late-twentieth century, but as social history has matured, the quantitative approach was overshadowed by cultural history. I aim to re-introduce the topics and themes of quantitative history to the field of the history of medicine in a way that is sensitive to the themes raised by institutional and social histories of medicine.

Historical demography in the 1960s was the first field to examine the movement, health, and structure of population within a particular place and context. The earliest historical demographic work focused on mortality, fertility, and family structure, using indicators of age, income, and health from national censuses and other government

documents, such as bills of mortality and parish registers, to track births and deaths.[2] As access to a wide array of censuses from assorted time periods and geographical regions were processed and became more accessible, historical demographers began to examine migration.[3]

Anthropometric history grew out of economic historians' desire to understand the effects of economic trends on stature. Anthropometric histories of the 1980s had a specific focus on determining and explaining diachronic changes in the health trends of populations. The work of economic historian John Komlos laid the foundational theory and quantitative methods of anthropometric history, which included insights from anthropology, biology, history, and economics.[4] Height was the primary focus of Komlos's analysis, but other historians also analyzed weight and body mass. These data were then combined with economic and social data to explain trends in mean heights in populations and variation over time. Data for anthropometric research has usually been adapted from archival military records, including enlistment paperwork and military academy physical exam records.

An impressive body of literature uses statistical methods to study health and disease in history, but this work has rarely been conducted by medical historians or

---

[2] See, for example: A. J. Coale and S. C. Watkins, eds., *The Decline of Fertility in Europe* (Princeton, NJ: Princeton University Press, 1986).
[3] See, for example: Donna Gabaccia and Loretta Baldassar, *Intimacy and Italian Migration: Gender and Domestic Lives in a Mobile World* (New York: Fordham Unievrsity Press, 2010).
[4] See: John Komlos, *Nutrition and Economic Development in the Eighteenth-Century Habsburg Monarchy: An Anthropometric History* (Princeton, NJ: Princeton University Press, 1989); "An Anthropometric History of Early-Modern France, 1666–1766," *European Review of Economic History* 7 (2003): 159–189; "Nutrition and Economic Development in Post-Reconstruction South Carolina: an Anthropometric Approach," *Social Science History* 19 (1995): 91–116; "The Height and Weight of West Point Cadets: Dietary Change in Antebellum America," *Journal of Economic History* 47 (1987): 897–927.

published in journals dedicated to medical history. Thomas McKeown published one of the best known historical demographic works related to health in 1976. In his *Modern Rise of Population*, and related articles including "Food, Infection, and Population," and "Reasons for the Decline of Mortality in England and Wales during the Nineteenth-century," McKeown argued that decline in morbidity and mortality during the nineteenth-century was not due to advances in medical science, but rather from improvements in living standards, especially diet.[5] His argument was three-fold: (1) living standards, diet, and sanitation impact health; (2) sanitation and public health can be improved by government intervention; and (3) certain diseases may decline because of changes in diet and environment rather than medical science.

McKeown showed trends in morbidity and mortality by using national statistics from England between 1848 and 1854 and post-1901. McKeown's contemporaries criticized his research, not for his conclusion, but for the "problematic" data that he used. McKeown's demographic argument was based on data collected by the General Register Office of England, overseen by William Farr during the latter half of the nineteenth-century. The General Register Office collected birth and death records of the English population during the Victorian Era. Medical historian John Eyler examined this data in detail in his intellectual history of William Farr, *Victorian Social Medicine,* published only five years after McKeown's work on Victorian mortality.[6] Farr began his work in the General Register Office in 1839, a position he held until 1880. During his nearly four decades with the General Register Office, Farr examined death rates between "healthy"

---

[5] Thomas McKeown, *The Modern Rise of Population* (London: Edward Arnold, 1976).
[6] John Eyler, *Victorian Social Medicine: The Ideas and Methods of William Farr (*Baltimore: Johns Hopkins University Press, 1979).

and "other," usually urban, districts in England. His findings highlighted a contrast between city and country environments and how environment impacted health and disease. Put simply, Farr's analysis demonstrated a social gap between life span and environment. To Farr, a physician, statistics were a science of social reform.[7] This marriage of social and scientific medicine allowed Farr to maintain a professional relationship with both medical practitioners and social reformers (namely Sanitarians), all the while promoting the importance of maintaining appropriate vital statistics. Eyler understands Farr as a proponent of statistical and social science.[8] Farr developed foundational methodologies of demography and vital statistics and used these scientific methods to advance a social agenda. It is Farr's use of the statistics that Eyler and other medical historians have engaged with.

Gerald Grob has similarly approached medical statistics through his examination of an individual, Edward Jarvis, a nineteenth-century American physician, statistician, and public health advocate.[9] Jarvis attempted to establish a private medical practice in Massachusetts after graduating from Harvard Medical School in 1830. After twelve years of unsuccessful practice, he turned to medical statistics. For the duration of his career, Jarvis worked with the American Statistical Association and the United States Census Bureau with the goal of updating the quality of federal census data, which he believed to be essential to establishing appropriate, effective public policies. Despite Jarvis' significance to the history of the census in America, Grob focuses on this period of his

---

[7] Eyler, *Victorian Social Medicine* (ref. 6), 18.
[8] MJ Cullen also examined statistics in England during the same period. See: M. J. Cullen, *Statistical Movement in Early Victorian Britain* (Hassocks: Harvester Press, 1975).
[9] Gerald Grob, *Edward Jarvis and the Medical World of the Nineteenth-Century America* (Knoxville: University of Tennessee Press, 1978).

life only briefly. Instead, Grob examines Jarvis as an authority on insanity and the relationship between sex, class, and mental health in America.

Eyler, Grob, and their contemporaries were concerned with medical statistics in the nineteenth-century to the extent that these data can illuminate the stories of the men who carried out this work and the health policies that followed. While these historians worked within a context in which historical demography, which grew from medical topics of morbidity, mortality, and fertility, was at its peak, they do not engage with quantitative records related to health. This dissertation aims to change this by moving quantitative methods from an object of study for medical historians to a method of medical history.

In the late 1990s, medical historians flirted briefly with studies of health and disease from a quantitative perspective, highlighted by the 1997 publication of Joel Braslow's *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*.[10] Braslow draws from patient records of two California state psychiatric hospitals in the early twentieth century. Patient records at each institution included a transcript of the patient's court hearing, an admission history, physician progress notes, family questionnaire, and personal correspondence. Braslow used pieces of the patient records to construct a quantitative portrait of the institutional population, including trends in population growth, ratio of patients to hospital beds, and ratio of entering and discharged patients. However, these quantitative aspects are not the focus of his research or main argument. Instead, he uses physician notes to reconstruct the

[10] Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley and Los Angeles: University of California Press, 1997).

treatments offered to patients, most typically sterilization, shock therapy, and lobotomy. Although he is using patient records, he constructs an overview of the history of institutional psychiatric treatment during the early twentieth century and considers the supposed effectiveness of each therapy.

Braslow's work demonstrates a revival of quantitative methods in medical history. While his quantitative material is supplemental to the qualitative patient records, it nonetheless highlights trends in psychiatric treatment in twentieth-century America. My research continues to develop this renaissance of quantitative research in medical history. I use the inmate medical records from the Minnesota State Prison at Stillwater from 1853 to 1930 both qualitatively and quantitatively. A quantitative analysis of these records reveals trends in disease transmission, diagnosis, treatment, morbidity, mortality, and stature. I use patient case studies to highlight quantitative arguments, blending the methodologies from historical demographers like Komlos and medical historians like Braslow.

The quantitative approach I use here complements the narrative of a medical institution—in this case, a prison. The literature regarding prisons and medical institutions largely falls into two categories—macro and micro levels. Macro-level analysis often examines the place of prison and medical intuitions within society as a whole. Micro-level histories chronicle the history of a specific institution or the staff that worked within it, usually with the goal of situating that institution's importance with respect to the development of medical treatments.[11] Largely in response to this trend,

[11] For example, see: Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840–1883* (Cambridge: Cambridge University Press, 1984); Grob, Gerald.

social historians and other scholars have engaged with case study based histories of patients and their experiences in the health care system.[12] These approaches are often seen in opposition to each other, but I combine them by examining medicine in the American prison by looking at a population-level study, focusing on the inmates and the care that was crafted to rehabilitate them.

The institutional and patient histories discussed above have focused overwhelmingly on hospitals. The final way in which I aim to expand upon the existing historiography of medical institutions is to give prisons a place within them. Prisons are misunderstood institutions in historical literature. They are often seen strictly as instruments of social control.[13] Prisons were indeed instruments of social control, but correctional institutions, as implied by their name, also held therapeutic objectives that were enacted by the medical staff of the prison. Overwhelming emphasis on control, discipline, and retribution obscures the fact that healing and rehabilitation were also central to the mission and operation of American prisons, and that the interaction of these objectives provided the productive tension that shaped prison medicine. Examining the prison as social institution through the lens of medicine highlights the rehabilitative

---

The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920. (Chapel Hill: University of North Carolina Press, 1966.

[12] For example, see: Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987); Goldsmith, Larry. "History from the Inside Out: Prison Life in Nineteenth-Century Massachusetts." *Journal of Social History*, 31, no. 1 (1997): 109–125.

[13] See: Michel Foucault, *Discipline & Punish: The Birth of the Prison* (New York: Random House, 1995); David J. Rothman, *The Conscience and Convenience: The Asylum and its Alternatives in Progressive America* (Chicago: Aldine Transaction, 2002) (Originally published David J. Rothman, *The Conscience and Convenience: The Asylum and its Alternatives in Progressive America* (Boston: Little, Brown, 1980)); David J. Rothman, *The Discovery of the Asylum* (Chicago: Aldine Transaction, 2002) (Originally published David J. Rothman, *The Discovery of the Asylum* (Boston: Little, Brown, 1990).

aspects of correctional institutions and offers a contrast to the view that they existed primarily as instruments of control.

As the physician navigated the competing objectives of prison practice, he crafted a medicine that was distinctively suited to the prison context. Each of the five chapters that follow examines the development of medicine in the prison through a case study of the Minnesota State Prison at Stillwater. Each chapter focuses on a particular characteristic of medicine in the prison, and each chapter vignettes contributes to the argument that prison medicine was different from traditional private practice in the late-nineteenth and early twentieth centuries.

Outline

This dissertation begins with a discussion of prison history in late nineteenth and early twentieth century America. Chapter one discusses competing ideas about the rehabilitation of inmates, from moral, to labor, to medical reformation in America, by examining Minnesota State Prison at Stillwater as an illustrative case study. While these shifts occurred because of philosophical shifts in penology, the medical staff of the prison responded to each by shaping a medical practice that responded to the local economic and practical concerns of the prison. This chapter will lay the framework of evolving penological ideas and practices in America during the late nineteenth and early twentieth centuries. The chapters that follow will reference this structure to examine how medical practice responded to and shaped medical practice to respond to changing ideas of crime, criminality, and rehabilitation.

With this context in place, Chapter two examines the details of medical practice in the prison. I discuss the competing objectives of medicine in the prison at an individual level by examining the role of the prison physician. The prison physician at the Minnesota State Prison labored under the challenge of limited facilities in the institution's early years. The medicine that he practiced there had to adapt to these challenges. From the early years of the prison, the physician kept record of every inmate who entered. Foreign to outside practice, the medical form was a new form of recordkeeping in medicine. While these records were kept for penological reasons to track inmates through the penitentiary system of Minnesota, they served a tremendous advantage to practice in the prison. Its purpose was to track individuals, but the physician also used it to examine trends in the health of the population of inmates. He used these records to exert his power in the prison to make measurable improvements to the prison hospital, individual cellblocks, and medical technology in the prison.

Through a detailed examination of the management of tuberculosis in the prison, chapter three discusses how the prison physician navigated his day-to-day responsibilities. For example, tuberculosis demanded a medical response that was attentive both to individual treatment and to population health concerns. This chapter examines the demographic characteristics of the inmate population in both its general and medical aspects and uses the analysis of these trends to show how large-scale characteristics of the prison population and management of population health affected the individual treatment and care of inmates. In the physician's struggles to balance these

multi-level demands, we also see the practice of prison medicine at Minnesota State Prison at a crucial point in its formation.

Chapter four examines the physician's responsibility for the mental health of inmates at Minnesota State Prison at Stillwater around the turn of the twentieth century. The first medical professional responsible for the psychological rehabilitation of inmates was the prison physician in the late nineteenth century. This would become the responsibility of psychologists in the prison in the early years of the twentieth century. At first, the physician added new questions to the intake medical questionnaire to assess and keep track of individual mental health. He examined inmates for the so-called disease of criminality, and identified inmates who suffered from more severe forms of mental illness. These new diagnoses added an additional level of inmate classification, and expanded the role of the prison physician to encompass understanding of the minds of his patients. Classification was an important aspect of the prison physician's duties, and classification by psychological assessment was important in managing a growing inmate population. It also demonstrated how subdividing the population was a central aspect of medical practice within the prison, and demonstrated the power that the prison held as a proving ground for emerging precepts of psychological practice.

Chapter four continues the analysis of mental classification to identify the influence of psychology on the American penal system. The prison served as a laboratory of medical practice as psychologists entered the prison in the early twentieth century, where they put the precepts of a maturing field into practice. Through the utility they offered to prisons' punitive and reformative goals, psychologists gained professional

authority in the prison that they then aimed to expand to medical practice outside of the prison. The prison offered fertile soil in which new psychological ideas could be tested, and their implementation led to extensions of the new psychological framework.

The dissertation ends with an examination of the expansion of the prison medical system after prison medicine was well defined as a discrete area of medical practice. Chapter five discusses the development of the criminal asylum and its relationship with the Minnesota State Prison. As the population of the prison expanded during the early twentieth century, so did the need for more specialized medical care. At this stage, the physician's responsibilities at Minnesota State Prison had been thoroughly negotiated. When the physician had cases that too deeply strained his role, he could send inmates to another institution—the criminal asylum. This resolved some of the professional dissonance experienced by the prison physician by providing an alternative institution where therapy was the primary mission and, unlike traditional asylums, facilities were available to cope with dangerous criminals. While the prison physician dealt with this dissonance at an individual level, ultimately this institutional problem required an institutional intervention.

When inmates entered the Minnesota State Prison at Stillwater, they left most of their rights at the front gate. The only right they gained was access to healthcare. The prison physician took his responsibilities in the prison seriously, treating every inmate with the same care as he would in his private practice. Nevertheless, the physician faced challenges practicing medicine in the prison, where the care of inmates was complicated by a competing responsibility to maintain discipline and order of inmates. This tension,

however, was dynamic. Its challenges prompted the physician to use the prison as his laboratory of medical practice. In doing so, he tailored a form of medicine that met the disciplinary and rehabilitative goals of the institution in which he practiced.

Chapter 1:
The Principles and Practices of Penal Reform

Introduction

On September 9, 1971 inmates at Attica Correctional Facility in New York, upset about prison conditions, staged an uprising in a cellblock. Within two hours, the inmates of Attica had taken forty-two prison guards and civilians hostage. After five days of failed negotiations with inmates, the New York state police stormed the prison. Forty-three inmates and hostages died during the siege. The riots at Attica were not a singular outburst. A 1973 prison riot at Oklahoma State Penitentiary lasted an entire week, and left three inmates dead and the prison itself unusable. Other significant riots occurred in Idaho, California, and Texas in the 1970s. As these prison riots occurred across the United States in the 1970s, state and federal governments reexamined physical environments, living conditions, and inmate care practices in their correctional institutions.

These inmate riots inspired institutions across the United States to examine not only prison conditions, but also the rehabilitative mission and success, or lack thereof, of the institutions. One downfall of prison rehabilitation programs of the time was their inability to conform to social change and inmate needs. In many cases, the rehabilitative programs in the prisons were little changed from those designed around nineteenth-century philosophies of reform and adopted by the individual prisons in accordance with their institutional needs and economic incentives.

Growing cultural awareness of prison issues corresponded to a rising focus on social control in the historical literature.[14] Social historians examined how governments maintained order and how order was maintained in government institutions.[15] Michel Foucault and David Rothman established the social control framework.[16] Foucault used this framework in *Discipline and Punish: The Birth of the Prison*.[17] According to Foucault, prisons cannot be understood as separate from the society simply because they house social deviants; rather, he argued, prisons symbolize changing order in society and

---

[14] Prison historians often associate the first social histories of the criminal with sociologist Emile Durkheim, who understood society by investigating those who did defied social norms. These principles are highlighted in Durkheim's *The Division of Labor in Society* and *Professional Ethics and Civic Morals*. See: Emile Durkheim, *The Division of Labor in Society* *Glencoe, Ill.: Free Press, 1947). (Original Publication: Emile Durkheim, *De la Division fu Travail Social* (Paris: F. Alcan, 1902); Emile Durkheim, *Professional Ethics and Civic Morals* (London: Routledge & Kegan Paul, Ltd, 1957).

[15] David J. Rothman, *The Conscience and Convenience: The Asylum and its Alternatives in Progressive America* (Chicago: Aldine Transaction, 2002) (Originally published David J. Rothman, *The Conscience and Convenience: The Asylum and its Alternatives in Progressive America* (Boston: Little, Brown, 1980)); David J. Rothman, *The Discovery of the Asylum* (Chicago: Aldine Transaction, 2002) (Originally published David J. Rothman, *The Discovery of the Asylum* (Boston: Little, Brown, 1990)); Richard Sparks, Anthony E. Bottoms, and Will Hay *Prison and the Problem of Order* (Oxford: Clarendon Press, 1996). William G. Staples, "In the Interest of the State: Production Politics in the Nineteenth Century Prison," *Sociological Perspectives* 33 (1990): 375–395; Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991); Gerald Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920* (Chapel Hill: University of North Carolina Press, 1966).

[16] Social order focuses on social institutions and how they enforced behavior. Social Control examins the social and political aspects of behavior. Sociologists like Emile Durkeim engage in research about social control related to government prevention of chaos. Historians David Rothman and Gerald Grob focus on social order within American instittituions in the nineteenth and twentieth centuries. Prisons can be seen as insitituions of social order and social control, as the institutions themselves enforce behvioral control within them, but these institutions also remove devints from society in order to avoid coruption of society. I will use this literature to engage with both aspects of social maintenance, but will refer to it only as social control within this text.

[17] Michel Foucault, *Discipline & Punish: The Birth of the Prison* (New York: Random House, 1995).

so reflect central trends in how societies exert power over themselves.[18] To do so in the eighteenth century, prisons used corporal punishment to maintain order. By the nineteenth-century, prisons used regimen—structuring prisoners' daily lives was a form of social control.

Although Foucault's analysis of social control in the prison and society does not directly engage with studies of social control by historian David Rothman and sociologist Erving Goffman, these scholars explore similar themes and can be understood as responding to the same social and cultural concerns that defined the late-twentieth-century United States. In *The Discovery of the Asylum* Rothman analyzes the emergence of the prison in nineteenth-century American society.[19] Rothman argues that the prison emerged as a result of changing attitudes toward criminals and their behaviors. In order to maintain order in society, America needed places to maintain and reform the behavior of the criminals. What resulted was what Rothman called the "asylum," which he defined broadly as any institution that would reform criminals, juvenile delinquents, poor and indigent groups, mentally ill persons, and all others whose "abnormal" behavior might or did threaten society. As a result of coming to be understood as useful instruments to promote the health of society, prisons, almshouses, houses of refuge, and mental hospitals proliferated in cities and towns across the United States.

Goffman's *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, published almost thirty years before Rothman's work, examines prisons as part

---

[18] Foucault, *Discipline & Punish* (ref. 14), 13.
[19] David J. Rothman, *The Discovery of the Asylum* (Chicago: Aldine Transaction, 2002) (Originally published David J. Rothman, *The Discovery of the Asylum* (Boston: Little, Brown, and Company, 1990)); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961).

of his discussion of "total institutions" in American society. Goffman spent four years in American mental institutions observing the clinical setting, the results of which he used to create his concept of the "total institution." Goffman defined "total institutions" as "social arrangements which regulate, under one roof and according to one rational plan, all spheres of individuals' lives—sleeping, eating, playing, and working."[20] Goffman's definition of "total institutions" nearly mirrors that of Rothman's definition of "asylum." Both authors use these terms to define not only prisons, but all public, government-run residential institutions; however, Rothman focuses his discussion on prisons, and Goffman on mental asylums.

The social control school advanced a series of frameworks within which to examine the place of the prison in American history that all revolved around a shared set of themes: the function of the prison in society;[21] the responsibility governments have to maintain the deviant; the physical condition and structure of prisons;[22] and inmate rights within prison walls.[23] Social control historians assumed that an institution operated with a

[20] Goffman defines "total institutions" as "social arrangements which regulate, under one roof and according to one rational plan, all spheres of individuals' lives—sleeping, eating, playing, and working." Goffman, *Asylums* (ref. 16), 5–6.
[21] See, for example: Estelle B. Freedman, *Their Sisters' Keepers: Women's Prison Reform in America, 1830-1930* (Ann Arbor: University of Michigan Press, 1981); Richard Sparks, Anthony E. Bottoms, and Will Hay *Prison and the Problem of Order* (Oxford: Clarendon Press, 1996); David Garland, *The Culture of Control: Crime and Social Order in Contemporary Society* (Chicago: University of Chicago Press, 2001); Negley K. Teeters, "The Pennsylvania Prison Society: A Century and a Half of Penal Reform," *Journal of Criminal Law and Criminology*, 28 no. 3 (1937): 374–379.
[22] See, for example: Robin Evans, *The Fabrication of Virtue: English Prison Architecture, 1750–1840* (Cambridge: Cambridge University Press, 1982); Elaine Jackson-Retondo, "Manufacturing Moral Reform: Images and Realities of a Nineteenth-Century American Prison," *Perspectives in Vernacular Architecture* 8 (2000): 117–137; Norman Johnston, *Forms of Constraint: A History of Prison Architecture* (Urbana, IL: University of Illinois Press, 1998).
[23] See, for example: Allen Hornblum, *Acres of Skin: Human Experiments at Holmesburg Prison* (New York: Routledge, 1998); Allen Hornblum, "Subjected to Medical Experimentation:

singular view of penology. The dominant penological philosophies and systems in the late nineteenth century were the Pennsylvania and Auburn systems. The Pennsylvania System of penology was developed in Philadelphia, PA during the late 18th century. It was structured around the solitary confinement of inmates and moral reform through silent reflection. The Auburn System of penology, first developed in the 19th century, advocated solitary confinement of inmates, silence, and a strict work regime in the prison. It was created in response to the 18th century Pennsylvania System.

While the prison may have advocated a singular penal philosophy at an institutional level, this did not happen often in practice. The Minnesota State Prison at Stillwater is an exemplary case of this. The prison was organized according to the Auburn system and established numerous factories on the prison grounds that served to not only reform inmates through discipline and regimen, but also significantly supplemented the prison's annual budget. However, the daily practice of the prison often contradicted the precepts of the Auburn system's practice—the prison employed a chaplain to foster moral reform, an idea more central to the Pennsylvania system, offered library and educational services to inmates (through the Chaplain), and began to reward good behavior in the prison through the establishment of a parole system. The details of these systems are discussed below, but the critical point here is that actual practice often led individual prisons to borrow elements from multiple systems. This resulted in hybrid systems that worked to serve local social, political, and economic needs despite being inconsistent with the motivating philosophy of any given system of penal reform.

Pennsylvania's Contribution to 'Science' in Prisons," *Pennsylvania History* 67, no. 3 (2000): 415–426; Larry Goldsmith, "History from the Inside Out: Prison Life in Nineteenth-Century Massachusetts" *Journal of Social History* 31, no. 1 (1997): 109–125.

It is in this hybrid context where we have to examine the place and practice of medicine in the prison. Because Minnesota State Prison advocated aspects of both the Pennsylvania and Auburn system, the physician's job was complicated. According to the Pennsylvania system he was responsible for the mental and behavioral reform of inmates. At the same time, he was responsible for keeping inmates healthy to work in the prison factories to sustain regiment and discipline of the inmates, and the economic vitality of the prison. The overlapping means of reform created an unusual role for medicine in the prison, one that the physician would have to tailor not only to his inmate patients, but also to the competing institutional philosophies of reform that evolved with changes in administrative staff (especially the warden), penological research happening outside of the prison, and the growing population of inmates at the turn of the twentieth century.

The concept of reform is used in several ways below. These are related, but distinct in important respects. Reform was applied both to institutions and individuals. Advocacy groups have, at various times, sought to reform prison organization and structure in accordance with their perspectives on crime and criminality. These institutional reforms were often motivated by specific perspectives on how best to reform individual criminals. This task has been approached in two primary ways. First, as moral reform, which is the notion that it is possible to influence the character of an individual within an institutional context. Second, as behavioral reform, which supposed that individual character is fixed, but that the behavior of those with deviant characters can nonetheless be bent to the will of society. The following is a story of institutional reformers with differing perspectives on individual criminal reform. The influence of

their views, and their actions to advance them, shaped the structure and organization of American prisons—although not always in the way the reformers might have imagined—and in turn created the conditions that came to define the particular conditions that shaped the prison physician's roles and responsibilities.

History of the Prison in America

The Walnut Street Jail was established in Philadelphia, Pennsylvania in 1776. The jail's primary form of discipline was solitary confinement of inmates; however, overcrowding in the early years of the prison undermined this ideal of isolation. Between 1789 and 1799, the jail was called upon to house criminals in the growing city, but had no penological guidelines in place to guide the treatment or reform of those it housed. Inmates were not classified upon arrival at the prison. Food rations were small, often containing only enough calories for inmates to perform a full day of work. The low caloric intake was not a large concern to the prison administrators, as employment in the prison was inconsistent because prison work was a less than desirable trade. The jail made no attempt to reform inmates. In practice, the prison's sole social function was to punish and isolate criminals.[24]

In 1787, a coalition of Philadelphia social reformers, mostly Quakers, formed the Philadelphia Society for Alleviating the Miseries of Public Prisons.[25] The society's founding mission was to reform the structure and policy of the Walnut Street Jail. The society believed the prison should meet three major objectives: 1) public security, 2)

[24] Negley K. Teeters. *The Cradle of the Penitentiary: The Walnut Street Jail at Philadelphia, 1773–1835* (Philadelphia: The Pennsylvania Prison Society, 1955).
[25] Teeters, "The Pennsylvania Prison Society" (ref. 18).

reformation of prisoners, and 3) humanity "towards those unhappy members of society."[26] To achieve these goals, the reformers suggested a regimen of strict discipline in the prison. Silence was to be observed at all times. Convicts showing promise of reformation would be released with the court's approval.[27] Social reformers maintained that to meet minimal living standards and promote reformative reflection, all cells should contain a bed, a bucket, and a bible. In addition to the Bible, ministers would offer inmates religious instruction, which activists thought to be the key to behavioral and moral reform of criminals.[28]

The policies and practices suggested by the Quaker reformers were implemented at the Walnut Street Jail in the 1789. The policies exemplify the changing penological context in eighteenth-century America. The Pennsylvania reformers believed that, when isolated, "every prisoner was beyond the possibility of being made more corrupt…furnishing him with Christian duties promoted his restoration to the path of virtue, because seclusion was believed to be essential in moral treatment."[29] The reformers' advocated three central methods as a route to this style of reform: religious instruction, hard labor, and solitude to provide time for reflection. They promoted religious salvation by distributing bibles and mandating regular meetings with ministers.

---

[26] Negley, *Cradle of the Penitentiary* (ref. 21), 378.

[27] Harry Elmer Barnes, "The Historical Origin of the Prison System in America" *Journal of the American Institute of Criminal Law and Criminology* 12, no. 1 (1921): 35–60.

[28] Reform of the Walnut Street Jail also included physical reformation. The new prison, upgraded to a state penitentiary in 1787, now contained workshops where inmates would work in silence. When not at work, inmates lied, ate, and slept in solitary cells.

[29] Jennifer Grabner, *The Furnace of Affliction: Prisons & Religion in Antebellum America* (Chapel Hill: University of North Carolina Press, 2001), 206.The moral treatment of inmates was the primary form of rehabilitation in mental asylums in 19th century America. This form of treatment is discussed in chapter 5 with the treatment of the dangerous insane and the development of the asylums for criminals.

The reformers enacted their vision of work as a route to reform in a system of prison workshops. To consolidate the reformative gains made through religious teaching and physical exertion, they designed the prison in such a way that prisoners would have little or no contact with either other prisoners or guards. This strict isolation, it was hoped, would allow inmates could reflect upon their actions and embark upon a path to moral rectitude, and also remove them from bad influences and temptations.[30]

These reforms were the foundation for what became known as the Pennsylvania System of prison policy and inmate reform. The system was first fully enacted at the newly established Eastern State Penitentiary in Philadelphia, Pennsylvania in 1829. With the construction of a new prison, advocates of the Pennsylvania System were able to promote their solitary confinement ideal in a way that had not been possible in the older, smaller Walnut Street Jail even after its 1787 reconstruction. For example, prison labor, when permitted by the board of the prison, was performed in cells of Eastern State Penitentiary. All meals were eaten in cells. Cell walls were thick and prevented inmates from communicating with one another. The prison structure also included a small, private yard attached to each cell for private exercise by inmates. The need for solitary units guided the physical design of the prison and led to the famed radial design, pioneered by John Haviland, as shown in Figure 1.[31]

---

[30] Michael Meranze, *Laboratories of Virtue: Punishment, Revolution, and Authority in Philadelphia, 1760–1835* (Chapel Hill: University of North Carolina Press, published for Institute of Early American History and Culture, 1996), 10–15.
[31] Meranze, *Laboratories of Virtue* (ref. 27), 22–26.

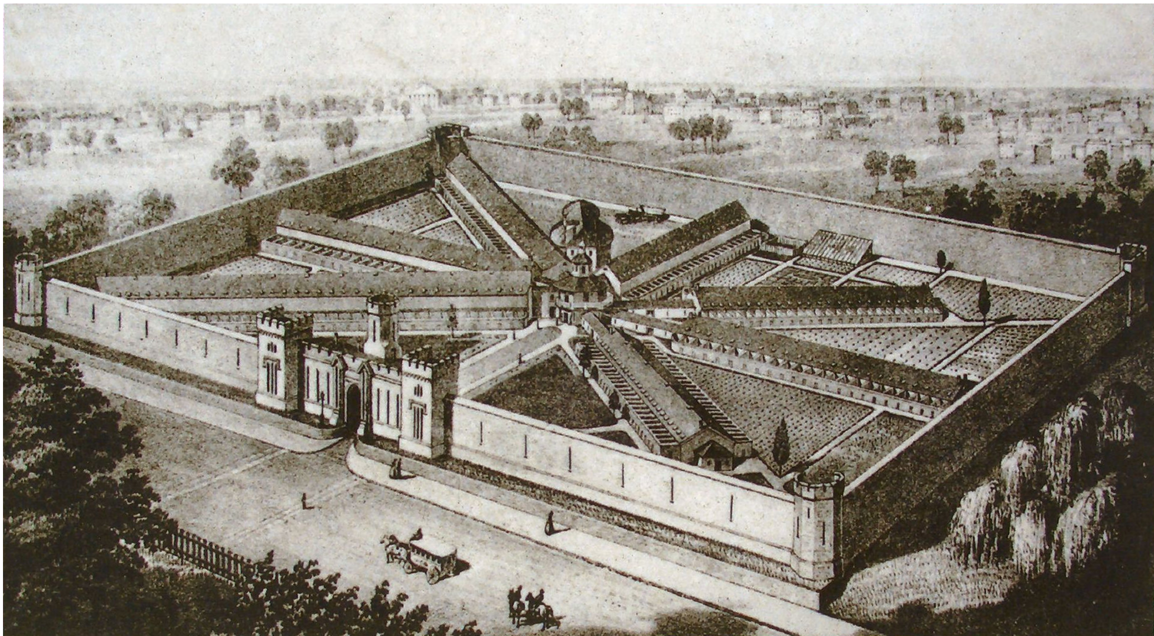

Figure 1: Aerial depiction of Haviland's radial design at Eastern State Penitentiary, 1855.[32]

Jeremy Bentham's Panopticon inspired Haviland's radial plan, departing from the traditional state-institution designs of prison, hospital, or asylums of the nineteenth-century. At the center of a structure stood an 80-foot tower, which served as a viewing platform for prison guards to observe all of the prison corridors from a single viewpoint. Seven single story wings radiated from the central tower. Several of the wings contained cells with their individual outdoor exercise areas. The tower guards could see inmates in the exercise yard, but inmates had no contact with one another. Eastern State was a penitentiary in the original, literal sense. The physical structure, which enforced strict solicitude, was designed to encourage introspection and, ultimately, penitence. Inmates were given time in their individual exercise yards at varied time throughout the day, as to diminish any possibility of an inmate communicating with other inmates. Haviland's

[32] The State Penitentiary for the Eastern District of Pennsylvania, Lithograph (Philadelphia: Duval and Co., 1855).

radial design of the Eastern State Penitentiary became the most widely copied prison format in the nineteenth-century United States, because the design made it possible for prison guards to view inmates in isolation. This design embodied a philosophy consistent with the Pennsylvania System, which was popular at the time, and it also offered substantial practical benefits to prison officials who worried about monitoring inmate behavior.

The Pennsylvania System gained worldwide recognition in the early nineteenth-century, both for its prison architecture and for the reformative philosophy that grounded it. Reformers from the United States and abroad visited Pennsylvania-style prisons, and implemented elements of what they saw into other systems of prison reform, most notably, the Auburn System. Auburn Prison, in Auburn, New York, was first organized around Puritan beliefs in 1823.[33] Puritans maintained that criminal behavior was a sign of rejection by God. Thus, no amount of religious or moral treatment could transform an individual. This was in stark contrast to the Pennsylvania System, built largely on Quaker beliefs that isolating criminals from bad environments could lead to behavioral and moral reformation. The Auburn reformers did not believe that moral reform of criminals was possible, so the system was organized around discipline and punishment, largely in the form of a strict regimen and work schedule.[34]

Prison labor in the Auburn Prison was meant to improve inmates by controlling their behavior, not reforming their character as the Pennsylvania system strived to do.

---

[33] Eastern State Penitentiary of Pennsylvania, *Prison Sentences: The Prison as Site, the Prison as Subject* (Philadelphia: Moore College of Art and Design, 1995).
[34] Philip Klein, *Prison Methods in New York State, a Contribution to the Study of the Theory and Practice of Correctional Institutions in New York State* (New York: Columbia University, 1920).

The reformers at Auburn prison believed that behavioral change came from "constant hard labor and the breaking of the spirit," and that this treatment "would bend the felon to the will of society." [35] The labor component of the Auburn System, according the mid-nineteenth-century social reformers, was beneficial to prisoners in that it strengthened "the moral convictions of the inmates."[36]

In addition to hard labor, inmates were subjected to a strict daily routine, which prison officials enforced, often violently. The inmates dressed in uniforms, ate together in dinning halls, and labored as groups in workshops. This contrasted with the solitary structure of the Pennsylvania System. Convicts marched in lockstep from their cells to their work assignments. Inmates occupied cells with gate doors that could be seen through by guards, visitors, and other inmates. Again, this was a grand departure from the costly design and demands of the Pennsylvania System's radial design of the prison. The Auburn System prison, which allowed more prisoners to be held in a smaller space, was much cheaper than the total seclusion demanded by Pennsylvania System. The lower cost and higher capacity were attractive to state legislatures, leading to this system's rapid proliferation across the United States.[37] The Pennsylvania and Auburn system existed simultaneously, in direct competition.

---

[35] Klein, *Prison Methods in New York State* (ref. 31).
[36] Orlando Faulkland Lewis, *The Development of American Prisons and Prison Customs, 1776–1845 with Special Reference to Early Institutions in the State of New York* (Albany: Prison Association of New York, 1922), 78.
[37] Norman Johnston, Forms of Constraint: A History of Prison Architecture (Urbana, IL: University of Illinois Press, 1998); Klein, *Prison Methods in New York State* (ref. 31); Larry Goldsmith, Penal Reform, Convict Labor, and Prison Culture in Massachusetts, 1800–1880 (Ph.D. diss., University of Pennsylvania, 1994). In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 9521039; accessed Jan 21, 2010).

Beyond cost saving and capacity, the Auburn System was attractive to many states because of its industrial focus. Auburn System prisoners, laboring in groups in prison workshops, could far out-produce prisoners laboring alone in their cells. The Auburn System triumphed over the Pennsylvania System of the late-eighteenth and early-nineteenth centuries not only because it partially paid for itself with the profit from its on-site industry and cost less to construct, but also because it created a "trained and disciplined labor force" fit for release into the industrializing nineteenth-century American economy.[38] The Auburn System "shifted from producing reformation to producing profits for the state."[39] By the 1830s, most American states allowed private businesses to contract prison labor. Prisons produced shoes, hats, saddles, wood furniture, and other crafts for private companies, which paid the state a premium for access to prison labor.

The Auburn System dominated nineteenth-century penology in America with its low-cost, high-capacity output of its prison labor. Additionally, the economic benefits of prison workhouses made most prisons with in-house industries self-sustaining, requiring very little funding from the state. The Puritan philosophies of reform and discipline fit the context of an industrializing nation. But, the Auburn system, economically productive though it was, struggled to meet its goal of altering inmate behavior. The crowded environment and punitive disciplinary approach tended instead to inure inmates to punishment and promote the growth of criminal networks with prisons. This condition set the stage for a new wave of penal reform.

---

[38] Klein, *Prison Methods in New York State* (ref. 31).
[39] Lewis, *The Development of American Prisons* (ref. 33).

In 1865, the newly established New York Prison Association (NYPA) recruited Enoch Cobb Wines, a penologist with a prime interest in behavioral modification, and Theodore Dwight, a well-known lawyer and prison advocate, to conduct a nationwide survey of American prison policy and procedure.[40] The NYPA maintained that the methods of the Pennsylvania and Auburn Systems were not reforming inmates and lamented the fact that, overall, the physical condition of America's prisons was poor. The NYPA felt that with improvements to the prison system nationwide, incarceration would better reform inmate behavior.[41] The NYPA focused on the reform of the prison as an institution, not the inmates they housed. They believed that reforming the institution would provide a suitable environment more conducive to the successful reform of inmates, in either the Pennsylvania or Auburn style, that is, keeping either the Pennsylvania or Auburn style, but making some changes to fit an individual institution.

After visiting and evaluating prisons across the United States, Dwight and Wines disseminated their findings in an 1867 publication titled *Report on the Prisons*.[42] Their report listed shortcomings of prisons, which included inadequacies in the physical structure, lack of appropriate training for guards and officials, and an absence of a supervisory structure to oversee the actions of the prisoners. Dwight and Wines also severely criticized the punishment procedure and methods observed by the New York state prison system, which had pioneered and continued to follow the Auburn System of

---

[40] Alexander Piscotta, *Benevolent Repression: Social Control and the American Reformatory-Prison Movement* (New York: New York University Press, 1994), 24.
[41] Piscotta, (ref. 37), 22
[42] Piscotta, (ref. 37), 28

penology.[43] The New York prison system was known for lashing, whipping, and flogging inmates for misbehavior, however minor the infringement. Inmates suffered significant physical injuries form these forms of punishment and were often not treated medically for these physical injuries.

To remedy these shortcomings, Dwight and Wines suggested ways to improve the quality of the America's prisons. This included the establishment of training programs for staff, the creation of state boards to inspect the physical structure and to oversee prison procedure, and numerous changes to the design of the prison itself.[44] Of most concern to Dwight and Wines was the reform of inmates. Dwight and Wines believed that prisons should not merely hold inmates until release, but rather prepare inmates for release; prison policy, according to this view, should reflect attempts to reform inmate behavior and even reward good behavior.[45] Each inmate would receive "…mental, moral, and industrial training which their own homes would never afford them, and from which they would at length be sent out to good situations in the country, where they would grow into virtuous and useful citizens…"[46]

The National Congress of Penitentiary and Reformatory Discipline echoed this sentiment in 1870.[47] The congress wanted to implement this theory in prisons across America. They held that "the prisoner's destiny should be placed, measurably, in his own hands; he must…able through his own exertions to continually better his own

---

[43] Piscotta, (ref. 37), 88.
[44] E. C. Wines, ed., *Transactions of the National Congress on Penitentiary and Reformatory Discipline Held at Cincinnati, Ohio, October 12–18, 1870* (Albany: Weed, Parsons and Company, Printers, 1871).
[45] Piscotta, (ref. 37).
[46] Wines, *Transactions* (ref. 41).
[47] Wines, *Transactions* (ref. 41).

condition."[48] The congress, following the recommendation of Dwight and Wines, advocated for indefinite sentencing of inmates, where the term of imprisonment was not determined by a judge or parole board, but by the inmate himself. The idea was that indeterminate sentences would provide inmates with incentive to guide their behavior toward recognizing norms. In the indeterminate sentencing system, an inmate would only be released when the trained prison officials adjudged him/her to be reformed.

On the heels of these efforts, prisons nationwide adopted indeterminate sentencing in the late nineteenth-century, especially in prisons that centered their missions on the Auburn style of penology. Dwight's and Wines's recommendations for the reform of inmate behavior were consistent with the Pennsylvania System commitment to moral reform. The founding Quakers of the Pennsylvania System believed that with proper moral and religious modification, criminals could repair their moral constitutions. The Auburn System prisons of the time, in line with the Puritan methodology of behavioral reform, punished inmates for not adhering the strict prison regiment. Dwight and Wines suggested rewarding inmates for good behavior in the prison instead of only punishing bad behavior. The reforms Dwight and Wines championed aligned well with the Pennsylvania System's tenet that environment could alter inmate character. These reformers did not advocate that system's radical physical structure, but instead maintained that a moral reform philosophy could succeed in an Auburn-style edifice.

---

[48] Wines, *Transactions* (ref. 41).

The success of the NYPA program can be partially attributed to the fact that the organization was not dogmatic about either the Pennsylvania or the Auburn system. American prisons in the mid- to late-nineteenth-century were facing concrete problems and wanted practical advice rather than philosophical purity. Dwight and Wines's suggestions were agnostic about the philosophical differences between the systems. Their proscriptions for penal reform include recommendations they imagined would work with either. Their pragmatic view paid off; their recommendations, especially that of indeterminate sentencing, were adopted by prisons nationwide. Their success was due, in part, to the spread of a hybrid form of penology. American prisons typically stated their mission according to a singular penal philosophy, usually either Pennsylvania or Auburn, but in practices day-to-day procedure included elements of both penological philosophies. The example of Minnesota State Prison at Stillwater, discussed in the next section, provides a case study in how systems of penal reform became hybridized.

The Minnesota State Prison at Stillwater, a History

When Minnesota became a state in 1851, legislators worked to establish three institutions they saw as fundamental to maintaining a successful society: a state house for state government, a university for education of its citizens, and a prison to house those who acted against the state. The prison had previously been under the control of the Minnesota Territory beginning in 1849.[49] Alexander Ramsey, the first governor of the Minnesota Territory urged the legislature to build a facility for criminals in his inaugural

---

[49] Prior to that date, the citizens of current day Minnesota fell under the jurisdiction of the Wisconsin Territory.

address in 1849. Due to the sparse, but concentrated, population of the Territory, Governor Ramsey recommended that an adequate state prison be built in lieu of many inadequate county jails.[50] The Minnesota state legislature petitioned the United States Congress in November of 1849 for a grant to build a prison in the Territory.[51] Congress granted $20,000 for this purpose in June 1850.[52]

Congress did not specify a location for the prison, and this was left to the state's discretion. Saint Paul and Stillwater were the Territory's largest cities in 1850.[53] As such, they were the most obvious choices for the location of the prison. In the same year, it was decided that Minneapolis would be the site of the University, and that Saint Paul would be home to the state capital. The prison, then, was left to the last sizable city in Minnesota—Stillwater. Stillwater, a timber town, had all of the materials needed to build the physical prison.[54] The legislature also argued that the stone quarries in Stillwater would be appropriate for inmate labor. On January 27, 1851, a bill passed through the legislature authorizing construction of a prison in Stillwater.[55]

The construction of the prison began immediately and was completed a year later, in 1852.[56] The site was a swampy bank of the St. Croix River, just two miles north of downtown Stillwater. The prison was composed of only a few buildings. The main prison

---

[50] "The Message of Governor Alexander Ramsey" *Journal of the Council during the Session of the Legislative Assembly of the Territory of Minnesota* (Saint Paul, MN: McLean & Owens, territorial printers, Sept. 4, 1849), 16.
[51] *Laws of the Minnesota Territory*, 1849, 168.
[52] *Minnesota Pioneer*, June 27, 1850, 1.
[53] *Minnesota Pioneer*, July 11, 1850, 1.
[54] *Minnesota Pioneer*, (ref. 50), 1
[55] *Minnesota Pioneer* Jan 30, 1851, 2.
[56] "Annual Message of Governor Alexander Ramsey," *Journal of the House of Representatives of the Legislative Assembly of the Territory of Minnesota* (Saint Paul, MN: J. M. Goodhue, 1852), 19.

building was 25 feet high, 45 feet long, and 30 feet wide with 18-inch-thick walls. The building had three floors, with approximately 15-20 cells on each floor, each opening into a central corridor.[57] In addition to space for inmates, the prison building included rooms for the guards, a kitchen, and a dual-purpose chapel and hospital room. The building was surrounded by a stone wall, fourteen feet high and four feet thick at the bottom, tapering to two and a half feet at the top. The wall, 280 feet by 200 feet, had rounded corners to prevent escape by inmates.[58] The structure of the Minnesota State Prison at Stillwater was a prime example of an Auburn-style prison. While the Minnesota prison had individual cells for inmates, it also included a number of communal areas, including a large capacity dining hall, group exercise area, and prison workshops.

The initial bill that allowed for construction also included the requirements for a suitable prison staff and administration. An additional bill was passed in 1853 to detail the exact responsibilities of each prison official and staff member.[59] The law stated that a warden appointed by the legislature should "be the principal authority to the prison."[60] His duties included the management and maintenance of the prison, the custody and discipline of inmates, and management of the financial records of the prison (personnel, inmate, industry, etc.). The warden was in command of the entire prison staff, including

---

[57] "First Annual Report of the Board of Commissioners." *Journal of the House of Representatives of the Legislative Assembly of the Territory of Minnesota* (Saint Paul, MN: J. M. Goodhue, 1852) 199–203.
[58] "First Annual Report of the Board of Commissioners" (ref. 54).
[59] Other officials appointed at this time included a Chaplain and a Physician. The duties of the physician will be discussed in detail in the chapters that follow. For more detailed descriptions of staff duties and responsibilities, see Appendecies C through G. See: "Annual Message of Governor Alexander Ramsey." "Annual Message of Governor Alexander Ramsey," *Journal of the House of Representatives of the Legislative Assembly of the Territory of Minnesota* (Saint Paul, MN: J. M. Goodhue, 1853), 19–20.
[60] "Annual Message of Governor Alexander Ramsey," (ref. 56), 19–20.

guards and other officials. The law also stated that a deputy warden, appointed by the Board of Control, would take over the responsibilities of the warden in his absence.[61]

The prison and its staff, including the warden, were under the authority of three newly appointed inspectors who would be appointed by the governor for two-year terms, one of whom was to be designated as the chairman.[62] The inspectors met once every three months with the warden, where they would advise the warden, review his records, and examine the overall status of the prison.[63] The prison experienced rapid physical expansion between 1855 and 1880, during which the number of cells at Stillwater grew from 22 to 582.[64] The first major expansion was completed in 1861, when the prison added a new building. In the same year, three cells in the new edifice were dedicated to housing female inmates. Additionally, the first floor of the new building had a dining hall and the second floor now housed a new hospital area. Formerly, the site of medical care was in a single room within a prison cellblock.

As inmate numbers rose steadily each year, the warden continued to worry about adequate space to house inmates. Only two years after the completion of the 1861 building, the warden petitioned to the State of Minnesota for money to expand the prison's capacity.[65] In 1863, the state appropriated $5,000 for the state prison to construct a new cellblock, which was completed the following year. This building was

---

[61] "Annual Message of Governor Alexander Ramsey," (ref. 56), 19–20.
[62] "Annual Message of Governor Alexander Ramsey," (ref. 56), 19–20.
[63] "Annual Message of Governor Alexander Ramsey," (ref. 56), 19–20.
[64] *Biennial Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Two Years Ending November 30th, 1880* (Saint Peter, MN: J. K. Moore, State Printer, 1881).
[65] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota Session of 1863* (Saint Paul, MN: Frederick Driscoll, State Printer, 1863), 37–39.

considerably larger than existing prison buildings, measuring 100 feet long, 42 feet wide, and three floors high. Each floor had 28 cells constructed of brick with iron doors opening to the main interior corridor.[66] With the completion of this building in 1870, the prison could now accommodate 78 inmates.[67]

The warden was not placated and continued to request funding to build more accommodation for inmates. The number of incarcerated individuals continued to rise annually, especially in the years after the Civil War as the population of the state grew. The Board of Inspectors followed up his next request in 1871. The inspectors investigated the capacity of the prison, the growing inmate population, the possibility of expanding the prison yard, and a possible timeline for additional construction at the prison.[68] These inspectors presented their findings and suggestions to the Governor and State Board of Control the same year, but no action was taken until 1873, when the legislature approved the addition of 52 cells to the existing buildings.[69] The warden and prison inspectors were upset with this ruling and continued to appeal to the state for money to construct additional buildings. In 1875, the state again appropriated money for the expansion of existing cellblocks. The expansion of the cellblocks in 1875 increased the capacity of the

---

[66] Also, the plan calls for 28 cells to a floor with 14 per side, but photographs and descriptions of the actual construction appears to have had 26 cells to a floor with 13 per side. See: *Annual Report of 1863* (ref. 62), 39–40.
[67] The new building increased the overall number of cells available at the state prison. The prison, however, also lost cells in this year when the cells in the main building, constructed in 1853, were decommissioned as inmate housing and reassigned for administrative use. *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1870* (Saint Paul, MN: Press Printing Company, 1871).
[68] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1871* (Saint Paul, MN: Saint Paul, Press Printing Company, 1872).
[69] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1873* (Saint Paul, MN: Saint Paul, Press Printing Company, 1874).

prison to 210 cells.[70] Eventually, a new cellblock was built in 1878, which accommodated 84 additional inmates.[71]

In addition to cell expansion and construction in the late-nineteenth-century, prison officials were also concerned with expanding the prison workshops to accommodate the growing inmate population. The first legislation related to an increase of workshop space in the prison appeared in 1867.[72] The warden appealed to the legislature for a second machine shop to be built. The legislature approved funds for a new shop two years later, which provided work room for 150 inmates.[73] For the next decade, no further shops were built.

The Minnesota State Prison at Stillwater employed the Auburn System of penology through the late nineteenth-century—inmates were housed in individual cells and they worked together in prison factories and workhouses during the day.[74] Inmates were punished, usually by placement in solitary confinement, for violating the strict

---

[70] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending Nov. 30, 1875* (Saint Paul, MN: Pioneer-Press Company, 1876).

[71] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending Nov. 30, 1878* (Saint Paul, MN: Pioneer-Press Company, 1879).

[72] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota Session of 1867* (Saint Paul, MN: Frederick Driscoll, State Printer, 1868)***;*** *General Laws of the State of Minnesota Passed During the Session of the State Legislature***,** 1867, Chapter CXII.

[73] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending Nov. 30, 1875* (Saint Paul, MN: Pioneer-Press Company, 1876).

[74] During this time prison guards limited communication between inmates. Changes to policy and practice in the prison changed during this period as well. The warden (Proctor) changed inmate uniform. The new uniforms, consisting of a" hip jacket, wool pants, and a skull cap," all in black and white horizontal stripes, were changed to help detect escaped inmates. See: *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1873* (Saint Paul, MN: Saint Paul, Press Printing Company, 1874), 4.

prison rules.[75] The Auburn system was suited to actual conditions on the ground in the United States. Minnesota used the Auburn system because it was practical and the state was interested in the growing the economic vitality of the prison, but the prison administration and state legislature were not wedded deeply to the Puritan philosophy behind it, which meant the prison still had room for individual inmate reform.

One way in which Minnesota State Prison sought to enact moral reform was through labor. In 1881, the State of Minnesota contracted prison labor to Seymour, Sabon, & Co. The contract ended in 1888, and Minnesota decided to reclaim convict labor in the state. Having not managed prison labor in almost a decade, the state had to evaluate the state of convict labor in Minnesota and throughout the country in order to establish a system that was mutually beneficial for the inmates and the state. Over the course of the year, the Board of Inspectors of the State of Minnesota conducted this state and nation-wide evaluation by contacting wardens of state penitentiaries inquiring about their convict labor, its success and troubles, and soliciting suggestions for labor in Minnesota. Their findings, which came with but a few suggestions, were published in 1889.[76] Critically, however, this report indicates that the Board of Inspectors understood labor as a vehicle to moral, not just behavior reform. They concluded, for example, that "labor is indispensible to convict life and that to be of any reformatory character it must be productive, which means producing something useful for consumption."[77] The focus

[75] These punishments ranged from withholding inmate privilege to solitary confinement. Punishment of inmates was determined by prison officials based on the circumstance and frequency of criminal behavior.
[76] *Special Report of the Board of Inspectors of the Minnesota State Prison on the Subject of Convict Labor*. (Minnesota: J.W. Cunningham, State Printer, 1889).
[77] *Report on Convict Labor* (ref. 73), 5.

on productive labor, rather than punitive labor, indicates that the Board was not tied to the Auburn System's Puritan philosophy of behavioral reform and focused on the moral reform of their inmates.

Despite being a representative example of the Auburn System, the Minnesota state prison showed evidence that it was open to new reforms that cut against the grain of strict discipline that characterized the Auburn System. This capacity, in part, came from the original legislation that created and defined the role of the prison in the State of Minnesota. The 1858 Laws of Minnesota stipulate that the state prison was "to be maintained for the reformation of the convict as well as for his punishment and custody."[78] The laws also indicated that each inmate who could read was "given the Bible and the inspectors were to appoint a part time Chaplain to serve as one of the officers of the prison."[79] The care the legislature took to ensure that inmates had access to religious instruction indicates that the concept of "reform" they had in mind was closer to the moral recovery ideal than it was to the Puritanical behavior modification regime.

Despite this fact, the late nineteenth-century legislature did not provide funding for a full-time chaplain to carry out his religious duties in the prison. [80] Throughout this period, the prison staff included part-time Protestant and Catholic chaplains, who led

---

[78] *General Laws of the State of Minnesota Passed During the Session of the State Legislature***,** 1858, Chapter XXXIV, Section 1.
[79] This reform in the prison was clearly in the form of repentance, which was also reflected in the creation of a prison library. The prison library was established only two years after the creation of the Minnesota State Prison. The library collection, at this time, was entirely composed of books and periodicals that "carried a moral lesson" and were "deemed as an essential factor in the process of reform. See: *General Laws of the State of Minnesota Passed During the Session of the State Legislature***,** 1858, Chapter XXXIV, Section 7.
[80] *General Laws of the State of Minnesota Passed During the Session of the State Legislature***,** 1893, Chapter IX , Sections 5 and 27.

religious services on alternate Sundays.[81] Inmates were not required to attend religious services or to meet with the chaplains, but the guards and warden urged inmates to attend services.[82] Inmates could request meetings with the prison chaplain, which occurred in individual inmate cells. During this time, chaplains offered the inmate moral and religious counsel, and, sometimes, aid in corresponding with friends and relatives.[83]

In practice, reformation of inmates was largely the responsibility of the prison chaplain in the mid-nineteenth-century, although this was not explicitly stated in his explanations of duty.[84] The chaplain held weekly chapel services, managed "spiritual consultation" with inmates, ran prayer groups, and taught literacy, both reading and writing.[85] In addition to his religious duties, the warden appointed the chaplain as the directory of the library in 1867.[86] As director of the library, the chaplain selected books, newspapers, and magazines for the collection.[87]

---

[81] *Sixth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1890.* (Saint Paul, MN: The Pioneer Press Company, 1890), 40.

[82] *Fourth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1886* (Saint Paul, MN: The Pioneer Press Company, 1886), 64.

[83] In addition to religious reformation, the Minnesota State Prison at Stillwater stressed reform through on-site labor, consistent with the Auburn System of penology. All inmates were to be taught a trade/vocation during their stay at the Minnesota State Prison. A law passed in 1889 designated the warden the responsibility of assigning inmates to labor assignments (other word?). See: *Fourth Biennial Report, 1890* (ref. 79), 459.

[84] See Appendix G for the list of duties of the prison Chaplain.

[85] *Annual Report of 1867* (ref. 69), 46.

[86] *Annual Report of 1867* (ref. 69), 314.

[87]In 1886, the warden appointed an inmate to run the day-to-day activities of the library. In 1888 this responsibility was delegated to Cole Younger, an infamous member of the Jesse James gang and arguably Minnesota's most family prisoner. At this time, inmates were not allowed to visit the library, only borrow material. Younger created the first catalog of library materials, which was placed in each inmate cell, enabling inmates to choose materials to borrow from the library. After an inmate selected material from the catalog list, items were delivered to inmates in their cells. See: Younger was also influential in creating the *Prison Mirror*, an inmate run prison newspaper,

The details of the chaplain's responsibilities in the prison, as compared with his delineated duties, indicate the broader sense in which reformative practices in American prisons were flexible. The penal philosophies that guided design and construction of American prisons, although they in some measure constrained the physical structures and activities in which inmates were engaged, were not rigidly enforced. The Minnesota State Prison underwent significant change in its approach to reform and imprisonment programs in the final decades of the nineteenth-century.[88] Parole, for example, was introduced during this period. Parole was extended only to a select group in the 1880s, but was gradually extended to the full inmate population through the early twentieth century.[89]

Parole was initially introduced at Minnesota State Prison to address the growing population of the state and the prison. As the state population grew, so did the entry rate into the state prison. In the late nineteenth-century, the prison advocated for indeterminate sentencing, promoted by Dwight and Wines as an extension of the existing penological philosophies of the era. Indeterminate sentencing kept inmates in the prison until they were judged by prison officials to be adequately reformed and prepared to

---

in 1887. See: "Cole Younger's Own Account of the Northfield Raid, as Told to Dr. A. E. Hedback, Prison Physician at Stillwater in 1897, Is Now Published for First Time," *The Minneapolis Tribune,* November 21, 1915, C5; "Five Years in Prison," *The Minneapolis Tribune*, September 15, 1899, 7.

[88] Outside of the Minnesota State Prison at Stillwater, the State of Minnesota constructed separate reformatory buildings to house young, first offenders. These inmates were sent from the prison to the reformatory at the time that the reformatory opened in 1889. Older first offenders, over the age of 21, however, were subject to a newly established reformatory program at the Minnesota State Prison beginning in 1893. At the end of the program, inmates were reviewed by a parole board and released under the supervision of a state agent. See: *General Laws of the State of Minnesota Passed During the Session of the State Legislature*, 1893, Chapter IX.

[89] *Fourteenth Biennial Report of the Minnesota State Prison (1905–1906)* (Stillwater, MN: The Mirror Office, 1907).

contribute to society. With a significant population in the prison not being released, the increasing number of inmates entering the prison caused problems with overcrowding. Having too many inmates in the prison made it difficult to maintain key aspects of the prison's reform philosophy, such as keeping inmates in individual cells while outside of the prison workshop. The growing population forced the prison administrators of Minnesota to borrow elements from other penal philosophies to handle the growing inmate population. The adoption of parole allowed for inmates to be released from the institution at a more consistent rate, and introduced the concept of rewarding inmates for good behavior in the prison system. This differed from the Auburn system under which the prison was initially established, which advocated for discipline and punishment, but not reward. The prison relied on administrative staff to identify new methods and revise the prison's reform philosophy to evolve with changes in the prison's population.

Even with the addition of parole in the changing penology environment, the prison continued to stress religion, labor, and education as the primary means for reforming inmates, as opposed to offering incentives. As the prison became more conscious about the reform methods it was employing, penology-trained staff members were added to the prison administration. In 1891, Minnesota State Prison hired its first penology-trained warden, Albert Garvin. Warden Garvin received his training in the Illinois state prison system, a system of largely experiential learning and orientation of penological foundations through material published by the National Prison Association. Garvin only remained at the prison for one year before assuming the position as the chief

of police in Saint Paul, Minnesota.[90] Another trained penologist, Henry Wolfer, succeeded him in 1892. Warden Wolfer remained at the prison through 1914, during which time a new era of prison management and labor emerged. Warden Wolfer's introduced conditional pardons to "deserving men" on an experimental basis, a policy that was passed into state law the following year.[91] The most significant change in Minnesota penology during Wolfer's tenure was the Indeterminate Sentence Law, adopted by the Minnesota legislature in 1911.[92] Under this new law, consistent with the penological recommendations of Dwight and Wines, all offenders, except those guilty of murder or treason, were sentenced to prison without a specific term length or release date. Inmates were released from the Minnesota State Prison only when the prison board believed an inmate to be "suitable to transaction and social exchange in the outside world."[93] The Indeterminate Sentence Law was consistent with the recommendations of Dwight and Wines in their 1890s publications, and another way in which the Minnesota State Prison did not strictly align with one penological philosophy.

The indeterminate sentence law significantly altered the inmate population of the Minnesota State Prison at Stillwater, as did the demographics of the State of Minnesota. With fewer inmates being released from the prison, and more a growing state population, the Minnesota State Prison population grew significantly between the nineteenth and

[90] Warden's notebooks, 1888–1889 and 1890–1912. Washington Country Historical Society, Stillwater, MN.

[91] Warden's notebooks, 1888–1889 and 1890–1912. Washington Country Historical Society, Stillwater, MN; *Eighth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending July 31, 1892* (Saint Paul, MN: Pioneer Press Company, 1892).

[92] The death penalty was also formally abolished in this year. See: *Seventeenth Biennial Report of the Minnesota State Prison* (1911–1912) (Stillwater, MN: The Mirror, 1912).

[93] *Seventeenth Biennial Report, 1912* (ref. 89), 112.

twentieth centuries. The population of Minnesota increased 58% between 1880 and 1930, with the urban population of the state increasing 94% during this time.[94] In 1880 the prison housed 437 inmates; in 1920 there were 814 inmates.[95] The growing state population in Minnesota also increased the number in inmates entering the prison. In 1880, the Minnesota State Prison received 259 inmates. In 1920, the prison received 376 inmates, an increase of 68%. The number discharged did not change significantly, with approximately 260 inmates being released per year between 1880 and 1920.[96] The few inmates that left the prison were released through the newly established parole system. Parolees constituted a larger percentage of those released between 1895 and 1900, rising from 24% in 1895 to 33% in 1920.[97]

The age composition of the inmates was immediately affected by the opening of reformatories in Minnesota. Reformatories in Minnesota began as institutions for juvenile offenders, and later expanded to include a reformatory for women offenders. In 1888, 65% of the inmate population was under the age of 30.[98] By 1890, this percentage dropped to 51% and dipped under 50% after 1900, remaining under that mark for the next two decades. Between 1900 and 1920, approximately 40% of inmates received were

---

[94] Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

[95] Inmate Records, Minnesota Historical Society, Saint Paul, MN; also referenced with *Biennial Report of 1880* (ref. 61); *Twenty-first Biennial Report, 1920* (ref. 39).

[96] In 1880, 256 inmates were released from the prison; in 1920, 271 inmates were released. See: Inmate Records, Minnesota Historical Society, Saint Paul, MN; also referenced with *Biennial Report of 1880* (ref. 61); *Twenty-first Biennial Report, 1920* (ref. 39).

[97] *Ninth Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1896* (Saint Paul, MN: Pioneer Press Company, 1896); *Twenty-first Biennial Report, 1920* (ref. 39).

[98] *Sixth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1888* (Saint Paul, MN: The Pioneer Press Company, 1888).

under the age of 30.[99] The most noticeable shift took place in the age of those sentenced to prison during the first ten years of the newly established Minnesota Reformatory system. Most first offenders under the age of 30 were likely sent to the reformatory.

These shifts in the prison population affected the approach to reform of inmates. The warden urged the Board of Control to choose between two alternatives for addressing the problem of the rapidly growing prison population—the relocation of the prison on one hand and its reconstruction on the existing site on the other.[100] The Board of Control endorsed the first alternative. This was due, in part, to two fires at the prison in January, 1884. On January 8, the prison woodworking shop, along with four small buildings surrounding it, burned.[101] On January 25, a fire started in the basement of the machinery shop. It spread quickly through half of the prison buildings, including two cellblocks. The fire left the prison in ruins; the walls of the prison left black from smoke and most of the cellblocks had also been either destroyed by the fire or damaged from smoke. The prison hospital, library, and furniture workshop, along with all of many of their contents (instruments, files, etc.) were destroyed. The only surviving documents were the prison records in the administration building, which included the inmate registers, medical registers, financial documents, and inspector's notes. No inmates escaped. With no living quarters for the inmates, Warden Wolfer requested that inmates be transferred to county jails. He sent the state prison guards as additional staff for the now full county jails. *The Daily Globe* of Saint Paul, Minnesota described the sight as

---

[99] Women were removed from the sample for all of these statistics. The population of women in the prison did not exceed 5% during these years.
[100] *Fourth Biennial Report, 1886* (ref. 79).
[101] "Fire Strikes Stillwater Prison," *The Daily Globe*, Saint Paul, MN, January 27, 1884.

follows: “The appearance of prisoners chained two and two, dressed in their striped clothes created quite a sensation as they marched down the main street of Stillwater to the railroad depot.”[102]

Repair of the fire-damaged buildings began within days of the January 25 fire.[103] Construction workers built temporary roofs on cellblocks and work on the workshops began soon after. All of the work was temporary and the warden used this as leverage to ask the State Board of Control to find a new site for the state prison. In addition to the fire damage, the warden also cited the dampness and poor ventilation of the current prison buildings, as reported by the prison physician during his annual reports during previous years. The warden called the air of the prison “stale, and the stench almost intolerable.”[104]

Warden Wolfer conveyed these arguments for a new prison in his annual report to the Governor in 1902 and again in 1904.[105] In 1905, the Board of Control purchased a plot of land on a plateau 2.5 miles from the old prison. The location on a 22-acre plateau overlooking the St. Croix River was deliberately chosen for its proper drainage and ventilation, which were both issues at the swampy site on which the old prison was built. The blank slate afforded the warden the opportunity to enact his vision, a hybrid of penological philosophies, for inmate reform through the creation of an entirely new

---

[102] “Fire Strikes Stillwater Prison” (ref. 98). The same article also explains that the warden took-in the female prison matron, along with the six female inmates, at his home in Stillwater until they were transferred to the reformatory in Winona, MN. This is also described in the warden's personal papers. See: Warden’s notebooks, 1880–1889 and 1890–1912. Washington Country Historical Society, Stillwater, MN.

[103] *Fourth Biennial Report, 1886* (ref. 79).

[104] *Fourth Biennial Report, 1886* (ref. 79), 22.

[105] *Twelfth Biennial Report of the Minnesota State Prison (1901–1902)* (Stillwater, MN: The Prison Mirror Print, 1903); *Thirteenth Biennial Report of the Minnesota State Prison (1903–1904)* (Stillwater, MN: The Mirror Print, 1905).

prison structure and environment. The structure of this new site, which opened in 1912, can be seen in figure two.

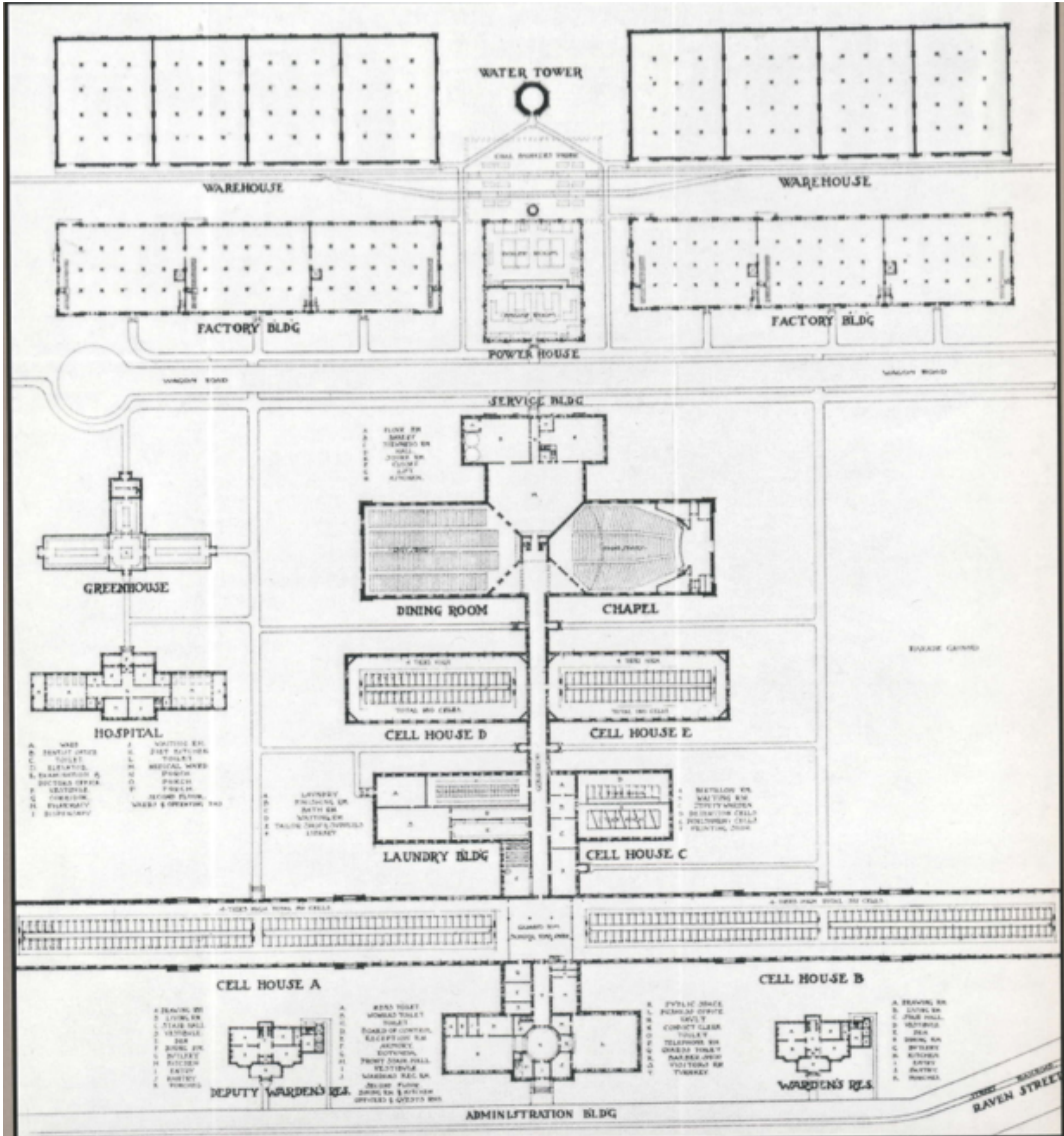

Figure 2: Ground plan of the new site of the Minnesota State Prison at Stillwater, 1909. Opened 1912.[106]

[106] Architectural plans of the state prison, blueprints for the new prison, 1909. Printed in: *Sixteenth Biennial Report of the Minnesota State Prison (1909-1910)*. Stillwater, MN: The Mirror Office, 1910.

The new prison facility included two cell houses with a total of 512 cells. The cellblocks were constructed of reinforced concrete. Each cell was 6 feet wide, 9 feet long, and 8 feet high. Behind the cell houses were two additional buildings, one with a bathhouse, tailor shop, and storage space, and the other with the deputy warden's office, the Bertillon room, receiving cells, and solitary confinement cells. Behind these two miscellaneous buildings was the prison chapel.[107] The central presence of the prison chapel[108] reinforced the idea of moral and behavioral reform in the prison, while the addition of a Bertillon room was evidence that the prison was beginning to adopt a system of classification.

Minnesota State Prison first adopted the Bertillon Method in 1887. The Bertillon method was used to identify inmates from one another by distinctive physical marks and unique measurements of individuals, none of which would have the same collection of measurements. The system was composed of three parts: First, the measurement of certain unchangeable "bony lengths" of the body; second, a careful description of the features of the face; third, a careful localization of all scars and marks on the body. Bony lengths were measured, as Bertillon argued, because bones remain unchangeable in adults. The bony lengths of the body measured included the length and width of the head, the cheek width, length of the foot, the middle and little finger and the cubit, i.e. from the elbow to the tip of the little finger; the height standing, the height seated, the reach of outstretched arms, right ear length, the median line in front of the fork or hollow below

[107] *Thirteenth Biennial Report (1903–1904)* (ref. 102).
[108] The chapel was roughly the size of a cellblock, and was centrally located on the prison grounds. The chapel's size and location indicate that it was a mechanism for religious, i.e. moral, reform.

the "Adam's apple" down, and, in the rear, the spinal column from the 7th vertebra to the base of the spine, are the anatomical "guiding points" from which all descriptions of the body were recorded.[109]

Medical staff also classified inmates through a physical exam, beginning in 1860. By classifying inmates upon entry to the prison, the prison medical staff could identify and treat criminals. Medicine offered a different way to approach the reform of inmates, but held the same goal of the moral reform practiced by the prison chaplain—the reform of inmate behavior. The prison was beginning to adopt medical practices for reform to exist alongside moral and labor reform methods that existed within the prison. The physician's report determined an inmate's labor and cellblock assignment.

Consistent with the Auburn system, the new prison also included expanded factories and space for labor. Two factories were built, one for farm machinery and another for twine making, along with two warehouses for these industries.[110] Barns, storage buildings, and granaries were built to accompany the farm machinery factory. The focus and increase in farming vocations at the prison represented a continuation of existing practice, and the emphasis on farming grew with the availability of new land at the relocated prison site. Additionally, the expansion to farm machinery production was consistent with the growing agricultural economy in Minnesota. With more farmers in

---

[109] Alphonse, "The Bertillon System of Identification," *The Forum* 11 (1891): 330-341
[110] Soon after the construction of the twin factory, Minnesota State Prison became the country's largest producer of twine. See: Thirty-First *Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years* (Saint Paul, MN: Pioneer Press Company, 1952).

need of equipment and equipment repair, the Prison could benefit from this need economically through their newly established prison factories.

Conclusion

The Pennsylvania system, established by Quaker reformers in the late eighteenth century, advocated moral or spiritual reform, and structured the prison to encourage individual penitent reflection. The Auburn system, in contrast, advocated behavioral change through a labor system with a strict regimen of discipline and punishment through a labor reform system. The Auburn system slowly overtook the Pennsylvania system in the nineteenth-century. Naïvely, this might be understood as an indication that the Auburn system's principles were more closely in step with the ideals of American society, but this interpretation does not hold up under scrutiny. Rather, the Auburn system succeeded because of its economic advantages, which were incidental to its philosophical foundations. Prison labor, although established by the Auburn system to instill discipline in the inmate, provided a significant economic boost to the prison. In the case of Minnesota, for example, the profits from the prison factories contributed almost half of the prison's operating budget by the early twentieth century.[111]

Nonetheless, prison administrators often had sympathy for the moral reform ideal that was the keystone of the Pennsylvania system. Aspects of the Pennsylvania system found their way into institutional practices, even if the system's expense mean that few institutions strictly adhered to the Quakers' original penological mission. In Minnesota,

[111] *Sixteenth Biennial Report of the Minnesota State Prison (1909-1910).* Stillwater, MN: The Mirror Office, 1910.

for example, the prison was established with the Auburn mission, but deviated from this philosophy in key ways. For example, the prison hired a full-time Chaplain to guide the moral reform of inmates and gave the Chaplain responsibility for educational aspects of prison reform as well. Within the rhetoric of labor reform, Minnesota State Prison administrators can be seen to deviate from the behavioral modification perspective that was the foundation of the pure Auburn system.

The case of Minnesota State prison is a complex penal history. The day-to-day practice of the prison exhibits elements of various penal philosophies. Examining the prison primarily through the lens of its singular stated mission, as the social control historians have tended to do, fails to acknowledge the complexities of penal practice. The prison staff of the nineteenth and twentieth centuries responded to quotidian concerns—economics, geography, and medical care. We see this in the mundane issues that guided the institution's evolution. The history of Minnesota State Prison at Stillwater provides a case study to show how elements of multiple systems combined to address immediate practical concerns. The prison adopted the Auburn physical structure and work environment, but tried to instill a Quakeresque notion of reform and rehabilitation. The efforts to negotiate this balance were complicated by population issues, which continued to be central to prison design and administration concerns. Prison administrators had to be understanding of the population and environment, which often resulted in new and changing prison policies. While Minnesota and other prisons throughout the United States were established under a common penal doctrine, they were not doctrinaire with respect to penal philosophies.

The complexities of penal practice at Stillwater established a system that pursued retributive, labor, and rehabilitative reform simultaneously. This made the job of the physician a difficult one, as he was responsible for shaping a practice that balanced all of these institutional goals while still discharging his medical duties to his patients. This delicate balance often manifested itself as a tension between the prison physician's institutional and professional obligations. As a result, the place and practice of medicine in the prison needs to be evaluated in terms of this tension. The characteristics that defined the prison physician's role within the prison, and the manner in which they came to define penitentiary medical practice, are the subject of the following chapter.

Chapter 2:
Making Medicine: The Role, Duty, and Difficulties of the Prison Physician

Introduction

In June 1888, an inmate at Minnesota State Prison in Stillwater, Minnesota reported to the daily sick call complaining of lower back pain. Dr. Willis Pratt performed a routine physical exam and failed to identify any abnormalities. The inmate was sent back to work in the on-site factory. Weeks later, the inmate reported to sick call with the same complaint, only to collapse before the physician could evaluate him. The patient died later that day.[1] Pratt reflected at length in the inmate's medical case file. He felt deeply conflicted. Upon initial examination, the inmate showed no physical signs of illness and the physician questioned if the inmate was attempting to sham illness to be relieved of the day's work. After the inmate's death, the physician recorded his remorse in the medical case report. The physician's inner conflict represented a tension in his role: on the one hand he was a healer, and on the other the representative of a punitive institution with clear economic goals. The physician and the Minnesota State Prison faced this and other challenges when building its medical infrastructure, and these challenges shaped the character of the medicine practiced within the prison.

Experiences such as these shaped Pratt's perspective on the prison's medical objectives. In 1886 he wrote: "The first objective of prison is to punish criminals for the commission of crimes as well as to hold them in confinement for certain length as protection of society. The second objective should be to fit the convict for usefulness

---

[1] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files. Minnesota Historical Society, Saint Paul, MN. 121.A.14.2, Box 1, Bound Ledger 3.

after his term of sentence has expired." Furthermore, Pratt learned to understand prison labor programs as integral to inmate health: "To throw out convict labor and keep men in confinement would not prepare prisoners for [the second objective] as their health would break down. Inmates would become insane, and each year would materially increase the already growing number of insane in asylums, to be supported by the state."[2] Pratt's comments are a commentary of the Pennsylvania System, as he saw confinement isolating, and work being beneficial to mental and physical health.

These reflections indicate that Pratt was aware of the tensions inherent in his role, but also that he was able to rationalize them and define a self-consistent set of principles that allowed him to navigate the pressures that often gave him conflicting incentives. This chapter discusses three defining features of medical practice within the prison that emerged from the pressures physicians felt within the prison and the strategies they evolved to manage them: 1) the physical constraints of medical practice, 2) the focus on both individual health and the health of the collective inmate population, and 3) the physician as disciplinarian and healer.

The Minnesota State Prison, whose budget was overseen by the state, funded medical practice in the prison. This meant that prison administrators often defined the space for medical practice. At Minnesota, the prison physician labored under limited space for practice until the prison itself moved in 1912, and a separate hospital building was added. Until that time, the physician practiced from one room in a cellblock, and eventually secured an entire cellblock wing for his medical practice in 1881. The

[2] *Fourth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1886.* (Saint Paul, MN: The Pioneer Press Company, 1886).

physician was empowered to shape the physical spaces in which his medicine was practiced. This was a critical tool for managing the defining tensions of his role.

In addition to treating inmates in the prison, the physician was responsible for the public health of the collective population of inmates. The physician recorded individual inmate medical histories and diagnoses in a medical register composed of a printed form. The use of medical records was unique to practice in a prison context, as medical records in hospitals and asylums in American were infrequently seen in the nineteenth century. At this time, the hospital record was largely a narrative one. The medical register at the prison was standardized with a form, and composed of both quantitative description and qualitative description. The physician used these inmate medical records to examine trends in diagnosis to prevent disease and promote health. Striking a balance between individual health and population health was a crucial aspect of the physician's role in the prison.

The physician recorded notes about difficult cases at the bottom of the inmate's medical form. It is in these notes that we see the difficulties the physician faced in diagnosing inmates with non-physical ailments. The physician faced characteristic challenges exercising his parallel duties to his patients and to the institution. Foremost among these was malingering, for which the penological literature, targeted though it was to the prison context, could not fully prepare him. While many prisoners exhibited physical injury sustained from labor within the institution and/or common infectious and chronic diseases such as tuberculosis, others claimed to be suffering from conditions that were difficult, or impossible, to test for. Although the physician felt it his duty to care for

the inmates as he would private patients outside the prison, he also knew that some prisoners attempted to sham illness in an effort to be sent to the prison hospital, where they would receive better care, food, and living conditions than the standard cellblocks, and where they would be excused from labor. Training literature for prison physicians noted the importance of being able to distinguish between real and sham illness, but offered few, if any, guidelines for this assessment.[3]

Medicine in Nineteenth-Century America

American physicians in the nineteenth century often learned their craft through apprenticeships with local healers. The quality of instruction depended largely on the preceptor's own training and experience. For example, physicians in rural areas had a small body of patients who they knew well and treated often. The rural setting itself also defined the types of cases that these physicians saw. Physicians trained in a rural areas would typically have learned to conduct a family-oriented medical practice that took place in the home, while a greater proportion of the patients seen by urban physicians and

---

[3] Training literature for training prison medical staff was published, most often, in penology, criminal law, and criminality journals. Articles related to training were often the product of collaboration among physicians, penologists, and legal specialists, and were often published without authors on the byline. For examples see: "Courses in Criminology and Mental Hygiene." *Journal of the American Institute of Criminal Law and Criminology* 13, no. 2 (Aug 1922): 279-280; "Proceedings of the Fourth Annual Meeting of the Institute." *Journal of the American Institute of Criminal Law and Criminology* 3, no. 4 (November 1912): 592-607; "Program for Sociology Course 104. State Care of Dependents, Defectives, and Delinquents in Minnesota." *Journal of the American Institute of Criminal Law and Criminology* 7, no. 2 (July 1916): 304-306; "Syphilis and its Treatment in a Reformatory for Women." *Journal of the American Institute of Criminal Law and Criminology* 9, no. 2 (Aug 1918): 276-279; "The Field of the Prison Physician." *Journal of the American Institute of Criminal Law and Criminology* 5, no. 6 (March 1915): 921-923; "Uniform Statistics in Institutions for Mental Diseases." *Journal of the American Institute of Criminal Law and Criminology* 10, no. 1 (May 1919): 148-149.

their trainees suffered from chronic disease for which they sought relief in private medical offices. In both cases, medical preceptors stressed practical over scholarly training.[4] Many students accompanied this training with academic education in a medical school, a tradition common across the United States.

Wealthy medical students often traveled to Europe to augment their training after completing an apprenticeship or medical school education in the United States. The University of Edinburgh, Scotland, was a popular destination for American medical students, where they would attend lectures by faculty physicians and continue their studies in hospitals. There, students paid the hospital for the opportunity to follow attendants, watch surgery, dress wounds, and attend anatomical dissections. Medical study abroad offered both scholarly foundations and a range of practical experience that students could not necessarily obtain through an apprenticeship.[5]

The quantity differential between aspiring healers who sought training abroad and those who learned their craft domestically motivated medical education reforms in 1870s America. Harvard, one of first medical colleges in the United States, extended its course of study to three years, added scientific subjects, such as chemistry and anatomy, to the curriculum, required laboratory coursework in which students would get hands-on

---

[4] See: Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999); Martin Kaufmann, *American Medical Education: The Formative Years, 1765–1910* (Westport, CT: Greenwood Press, 1976); Kenneth Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985); Steven Charles Wheatley, *The Politics of Philanthropy: Abraham Flexner and Medical Education* (Madison, WI: University of Wisconsin Press, 1988).

[5] Hugh Hawkins, *A History of the University Founded by Johns Hopkins* (Baltimore: The Johns Hopkins University Press, 1946).

experience.[6] Around the same time, plans for a new medical school at Johns Hopkins University in Baltimore, Maryland, were announced. Building the school from the ground up allowed the staff to shape the school around what they believed to be an ideal curriculum and to enforce rigorous standards—such as requiring a college degree for admission—leading to Hopkins's rapid emergence as a benchmark after it opened its doors in 1893.[7]

All competitive medical schools in the United States attempted to emulate Johns Hopkins.[8] The medical curriculum at Johns Hopkins, which was largely based on the German medical universities of the nineteenth century; in addition to requiring a bachelor's degree for admission to the medical program, Hopkins required laboratory work and science coursework in addition to clinical experience in university associated hospitals. Basic science faculty at the medical school were employed full-time, but the clinical staff at Johns Hopkins remained as part-time faculty members.[9]

The structure of Johns Hopkins Medical School starkly contrasted with the diploma mills that developed in nineteenth-century America. Four medical colleges were in operation in 1800, each associated with an established college. Together, they graduated approximately 343 students between 1800 and 1810. By 1850, the growth of independent medical colleges increased the number of graduates to 17,213.[10] These

---

[6] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Book, Inc., 1982), 114–116.
[7] Starr, *Social Transformation* (ref. 6), 115–118
[8] See: Michael Bliss, *The Making of Modern Medicine: Turning Points in the Treatment of Disease* (Chicago: University of Chicago Press, 2011); Kaufman, *American Medical Education:* (ref. 4); Ludmerer, *Learning to Heal* (ref. 4).
[9] Kaufman, *American Medical Education* (ref. 4)
[10] Starr, *Social Transformation* (ref. 6),

medical colleges were owned by the faculty and relied entirely on tuition to pay operating costs and part-time faculty. In order to maximize profits and minimize operation costs, they used lecture-based teaching to train students; the curriculum contained no clinical components. Independent medical colleges typically had lax standards, granting admission and degrees to any student who could pay the tuition, which resulted in the proliferation of physicians with medical degrees that said little about their practical experience or performance in their theoretical training.

The large number of poorly trained physicians from these schools threatened the wellbeing of patients across the country, and threatened the economic security and status of physicians. In response, the American Medical Association established a committee to evaluate and rate the quality of American medical schools with the hope of improving the quality of medical training, and thereby medical practice.[11] The AMA committee enlisted the aid of the Carnegie Foundation, which commissioned Abraham Flexner to produce a muckraking report on the status of medical education in 1910. The Flexner Report, as it came to be known, became the model for investigating other institutions in the following decades, including an evaluation of American prisons by physician Frank Rector in the 1920s.[12] Flexner assessed each medical school in the United States and Canada, ranking them into tiers, with the Johns Hopkins Medical School ranked first as the ideal medical training facility in all of North America.

---

[11] Kenneth M. Ludmerer. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999): 1-9.

[12] Flexner, Abraham. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*. (Boston: D.B. Updike, the Merrymount Press: 1910): 247-249; Rector, Frank Leslie. *Health and Medical Service in American Prisons and Reformatories* (New York: National Society of Penal Information, 1929).

For example, Flexner reported the overall quality of the University of Minnesota medical school, where most of the prison physicians after 1900 employed at Minnesota State Prison were educated, as "favorable."[13] The university received high rankings for basic education, but a low mark for "lack of convenient clinical facilities"[14] because the University's Elliott Hospital for clinical teaching, was still under construction and not completed until 1911. Flexner suggested that the lowest-ranked medical schools, mostly profit-driven independent medical colleges, should either reform or close. Many of these schools did close, as the cost of reform was prohibitive.[15]

Flexner's report helped to establish a standard of medical education in America. Like the University of Minnesota, many colleges and universities built hospitals to enhance clinical learning in accordance with the standards established by the AMA and Flexner's report. At the same time, the rising number of hospitals provided a place of care for individuals who could not afford a private physician or did not have family to care for them at home. Hospital patients at this time were usually the poor, urban workers, often single. Hospital trustees and physicians tried to weed out the "morally

---

[13] The Medical School at the University of Minnesota was established in 1882. The medical school required a degree from a college, a high school diploma, and knowledge of Latin and either French, German, or a Scandinavian language. The curriculum was three years in length. The faculty of the medical school at the University of Minnesota were not full time. They received compensation for the courses they taught, but this was supplementary income to their private medical practice. See: Leonard Wilson, *Medical Revolution in Minnesota: A History of the University of Minnesota Medical School* (Saint Paul, MN: Midewiwin Press, 1989); Arthur S. Hamilton, The Early History of Medicine in Minneapolis (Minneapolis, 1918).
[14] Flexner, Abraham. *Medical Education in the United States and Canada* (ref 12)
[15] See: Barbara Barzansky, *Beyond Flexner: Medical Education in the Twentieth Century* (New York: Greenwood Press, 1992); Steven Wheatley, *The Politics of Philanthropy: Abraham Flexner and Medical Education* (Madison, WI: University of Wisconsin Press, 1988); Starr, *Social Transformation* (ref. 6), 118–120; Ludmerer, *Time to Heal* (ref. 4).

unworthy" seeking hospital admission.[16] Most individuals went to the hospital because they had nowhere else to go; for many, entering the institution was a mark of defeat. Urban hospital patients had lengthy stays in the hospital, often up to ten weeks.[17] Patients with chronic diseases, though, still tended to be cared for in the home. Despite this, between 1880 and 1920 medical care in the United States moved from the home to the hospital.[18] The academic, and especially the clinical, training physicians received prepared them for practice in the growing hospital landscape of the United States in the late nineteenth and early twentieth centuries. This type of training is consistent with the

---

[16] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, Inc. Publishers, 1987), 48.

[17] Charles E. Rosenberg, "Institutionalized Ambiguity: Conflict and Continuity in the American Hospital," *Second Opinion* 12 (1989): 62–73; Charles E. Rosenberg, "Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880–1920," *Bulletin of the History of Medicine* 53 (1979): 346–391.

[18] The reason for patients pursing hospital treatment, and therefore a growth in hospitals, in the late nineteenth-century has been examined by a number of social historians, each offering a different reason as to why care moved from the home to the hospital. Social history revolutionized the history of residential medical institutions in nineteenth-century America. The social history of the American hospital became a central topic for medical historians in the 1980s, exhibited by a surge in hospital history publications. These historians argued that traditional medical history frameworks did not account for the cultural and social aspects of the hospital, particularly how the hospital developed into a central institution in American life. In order to understand the centrality of the hospital in American society, medical historians, such as Morris J. Vogel, examined the demographic and social forces that pushed members of the middle class out of their homes and into the hospital while sick or ill. To study the transformation of the hospital from a charitable institution to a profit-driven business, historians such as David Rosner appraised the American hospital in relation to the economy. To explain increase in cultural authority of the nineteenth-century hospital physician, social medical historians, like Charles Rosenberg, evaluated the relationships between physicians, patients, and staff of the nineteenth and early twentieth century American hospital. To understand the social cost and benefit of medical technology in the nineteenth-century hospital, historians like Joel Howell studied patient and public perceptions technological advances like the x-ray. See, for example, Rosenberg, *The Care of Strangers* (ref. 16); Morris Vogel, *The Invention of the Modern Hospital: Boston, 1870–1930* (Chicago: University of Chicago Press, 1985); David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (Cambridge: Cambridge University Press, 1982).

training physicians received to practice in the prison during the same period, which was largely based on clinical experience in the prison itself.

Physical Constraints of Medical Practice at Minnesota State Prison

From the time the Minnesota State Prison was founded as a territorial prison in 1849, the prison physician undertook a set of responsibilities distinct from what he likely faced in his private practice in Stillwater. The prison was built in an unfortunate location from the standpoint of drainage and ventilation.[19] It occupied a swampy area along the banks of the St. Croix River, just north of downtown Stillwater. Inmates suffered from a high incidence of respiratory disease undoubtedly linked to the swampy surroundings. The physician was concerned, often writing suggestions to the warden and Governor about ways improve health by bettering the physical environment of the prison.[20] The obvious solution was to relocate the prison, which the state could not fund at the time. Extra measures were taken within the prison to maintain a high level of sanitation to help reduce disease transmission.

The warden, the physician, and the State Board of Health became increasingly concerned for the overall wellbeing of inmates, which they understood to be their responsibility.[21] It is clear from their records that every effort was made to provide a stable diet, clean living conditions, and access to medical care. Despite the limitations of the prison's physical location, both inmate writings and reports of the State Board of

---

[19] *Sixth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1888* (Saint Paul, MN: The Pioneer Press Company, 1888), 23.
[20] The physician made his requests in his annual reports to the governor between 1860 and 1911.
[21] The responsibilities of each prison administrator can be found in Appendicies C-G.

Health, who conducted periodic inspections of the prison, indicate living conditions improved between 1858 and 1889.

During this time, improvements were noted in sanitation, institutional hygiene, inmate hygiene, and general comfort. For example, in 1858, toilet facilities in cells consisted of a wood bucket stored in the clothing closet. Buckets were emptied and washed every morning. In 1874, prison physician J. K. Reiner insisted that "dry earth" be used in the wooden buckets instead of the chloride of lime they had been using,[22] echoing an earlier recommendation by the State Board of Health.[23] In 1876, zinc pails replaced the wooden buckets,[24] again in response to a recommendation from the Board of Health, which had recommended that iron buckets replace the wood toilet buckets.[25] The Board of Health made the initial suggestion to eliminate the porous wood buckets, which it deemed conducive to the transmission of disease. The prison administration was keen to improve living and health conditions in the prison, but ultimately chose cheaper zinc buckets over iron because of budgetary concerns. These changes insured greater protection against the spread of disease, and made the hours of eating and sleeping in the cells more endurable. Following these changes, the Board of Health reported high levels of cleanliness within the prison cellblocks, or at least "as high as could be expected in

---

[22] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1874* (Saint Paul, MN: Pioneer-Press Company, 1875), 41.
[23] State Board of Health of Minnesota, *First Annual Report of the State Board of Health of Minnesota* (Saint Paul, MN: The Printing Press Company, 1873), 88.
[24] *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1876* (Saint Paul, MN: Pioneer-Press Company, 1877), 239.
[25] *Annual Report 1876* (ref. 24), 239.

light of the facility location."[26] The physician, in his reports to the warden, had only the most commendable words for the success of the efforts to improve hygiene.

The physician who inherited these changes after Reiner's departure was Dr. Willis Pratt, who worked in the prison from 1876-1888. Before joining the staff at Minnesota State Prison at Stillwater, he practiced medicine in Michigan. Willis H. Pratt was born in Hudson, NY, but spent most of his childhood in Michigan. He attended the University of Michigan Medical School, earning a degree in medicine in 1869. A year later, Pratt married Eliza J. Stephens. The Pratts remained in Michigan until 1871, at which time they moved to Stillwater, Minnesota and Pratt opened a small practice in the town.[27]

Pratt, upon arriving at the prison, judged that "the general level of cleanliness in the cell house and hospital [was] as high as could be expected in light of the facilities provided."[28] When inmates did fall sick, despite efforts to prevent the transmission of disease within the prison, the prison physician saw it as "[his] greatest endeavor as [physician and] surgeon…not only to render the best possible care to the sick, but also to watch carefully those who would be but are not sick; and thereby to save the state from being imposed upon by them."[29] Further, when inmates did fall sick, "the convicts

---

[26] State Board of Health, *First Annual Report* (ref. 23), 89.
[27] See: Albert Nelson Marquis, ed., *The Book of Minnesotans: A Biographical Dictionary of Leading Living Men in the State of Minnesota* (Chicago: A.N. Marquis & Co, 1907), 412; W. H. Pratt, "The Health of the City" *Stillwater Gazette*, Aug 22, 1904.
[28] . H. Pratt, "Annual Report of the Physician of the State Prison," in *Annual Report of the Warden of the State Prison* (Stillwater: Prison Mirror, 1876), 237.
[29] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN, 121.A.14.2, Box 1, Bound Ledger 3.

receive the best treatment, the best nursing, and the best diet that we are able to give them."[30] This was, however, within the limits of state provision.

From the time the prison was established, the physician labored under the handicap of limited facilities. His place in the prison had not yet been defined as an entirely necessary, nor professional, component in the prison hierarchy. By 1861, a single room was furnished for use as a hospital,[31] but it was always subject to being appropriated for housing healthy prisoners.[32] By 1873, new and more adequate space had been provided for a hospital and dispensary due to an increased number of inmates and demands for medical care.[33] Improved and enlarged accommodations were again made available in 1882, but were destroyed by the prison fire in 1884.[34] A rebuilding program begun to rehabilitate the prison structure after the fire included adequate accommodations and facilities for care of the sick and injured in the prison.[35]

---

[30] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN, 121.A.14.2, Box 1, Bound Ledger 1.
[31] *Annual Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota* (Saint Paul, MN: Pioneer Press Company, 1861), 589.
[32] J. K. Reiner, "Annual Report of the Physician of the State Prison," in *Annual Report of the Warden of the State Prison* (Stillwater: Prison Mirror, 1862), 716; J. K. Reiner, "Annual Report of the Physician of the State Prison," in *Annual Report of the Warden of the State Prison* (Stillwater: Prison Mirror, 1870), 582.
[33] J. K. Reiner, "Annual Report of the Physician of the State Prison," in *Annual Report of the Warden of the State Prison* (Stillwater: Prison Mirror, 1873), 615; Reiner states that "the hospital [was] functioning normally."
[34]James Taylor Dunn, "The Minnesota State Prison during the Stillwater Era." (*Minnesota History* 1960), 147.
[35] The Annual Report of 1874 (p.6) requested an enlargement of the hospital; the annual report of 1880 (p. 250-251), reported that the building was completed. Everything connected with the hospital was destroyed in the fire of 1884. Plans for a new hospital and dispensary called for a dispensary 15x18, a steward's room 10x18, a ward 17x18, a ward 18x59, a ward 10x30, a bathroom 7x11, 3 tight cells for the insane, an operating and convalescent ward, a main ward for the sick that was to be used as a dining room when not used for the sick. All of this was to be connected with the female department, where the meals were to be prepared. Additionally, each ward would be equipped with two fireplaces for the purpose of ventilation. Since there was co

Pratt became enthusiastically involved in the design of the new prison hospital in 1884. Concerned with environmental aspects of health and disease, he assured the warden and the legislature that the new structure would provide adequate ventilation and an abundance of light. More critical, to Pratt's mind, was the development of a sterile environment with separate wards for specific diseases. Since tuberculosis was the most prominent disease reported, he stressed the necessity of an isolation ward for such patients, although this was not established for almost two decades, until a new prison was built in 1912. Pratt identified a need for additional specific wards—one for the criminally ill, another for infectious disease, one for acute illness, and another for chronic disorders at the new prison site.[36]

The full range of concerns Pratt and other prison physicians expressed could only be addressed once a separate hospital building was constructed when the prison moved two miles down the road in 1912.[37] The hospital was composed of separate wards, a sterile room for surgery, examination rooms, a kitchen, dining room, and an office/records room for the physician. In addition to a new physical structure, the prison

---

complaint that this was not completed in the 1886 report, it can be assumed that this new hospital structure was completed. See: *Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1874* (Saint Paul, MN: Pioneer-Press Company, 1875); *Biennial Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Two Years Ending November 30th, 1880* (Saint Peter, MN: J. K. Moore, State Printer, 1881).

[36] The prison relocated in 1912 because its poor geographic and environmental location posed too many problems (lack of ventilation, swampy area, damp conditions, poor sewage, contaminated water supply because of stagnant pools of water, etc.). When the prison moved in 1912, a separate hospital building was erected, which allowed for disease and procedure-specific rooms. At the same time, the physician incorporated new technologies, such as x-ray and light therapy, and new surgical instruments.

[37] *Seventeenth Biennial Report of the Minnesota State Prison (1911–1912)* (Stillwater, MN: The Mirror, 1912), 51.

hospital now housed new medical technologies, including x-ray and light therapy.[38] The hospital was expanded a few years after its construction, providing for a new operating room and converting the old one into a sterilizing room and laboratory. In 1920, an extension to the east end of the old hospital made room for a new hospital dining room and kitchen.[39] Offices for a dentist and an eye, ear, and nose specialist occupied the space formerly used as the kitchen and dining room. The ward space also expanded.

The story of the physical space of care at Minnesota State Prison shows two trends. First, unlike community hospitals, the facilities for medical practice in the prison were constrained by a physical infrastructure whose primary goal was confining prisoners and was not always designed with medicine in mind. The Minnesota State Prison at Stillwater was initially built in an unfortunate location in terms of health, as the marshy land likely exasperated to respiratory illness among the inmate population. Additionally, the physician practiced in a limited space. The physician was given only one room to practice medicine in the prison in the mid-nineteenth-century. He gained control of individual cells for medical use as the population outgrew the small space he was initially allotted. There was an increasing need to segregate patients with infections disease, as Pratt and the medical field adopted the germ theory and the new bacteriological knowledge about contagion and infection into their medical practice.

Despite physical space limitations, a second trend worked in the opposite direction. The individual physician had much more input than a physician would have had at a general hospital. The prison physician was empowered to make measurable

---

[38] *Seventeenth Biennial Report, 1912* (ref. 37), 52.

[39] *Twenty-first Biennial Report of the Minnesota State Prison (1919–1920)* (Stillwater, MN: The Mirror Print, 1920,) 66–69.

improvements to conditions. When the prison moved to its new location in 1912, the physician was charged with the responsibility to suggest how cellblocks could promote health. And the physician dictated the plans for the on-site hospital, one that was fit for the growing inmate population and new medical technologies and practices. In this manner, prison physicians had some recourse for answering the limitations of the physical space in which they worked.

Population Focused Practice of Medicine at Minnesota State Practice

Just as the physician's relationship to the physical space in which he worked was different in a prison context than in a traditional hospital or home-based practice, so was his relationship with the people who populated that structure. Physicians received some specialized training for their position within the prison, which included mostly correspondence learning. Beginning in 1898, a specialized training regime conducted by the Minnesota State Prison was put in place to prepare the physician for the specific responsibilities he would assume. The self-guided tour through literature familiarized the physician with key concepts. Topics included penology, criminology, prisoners' families, physiology, and physical background, and the causes of deviance. The goal of this training was both to prepare the physician for the special character of prison medicine and to assimilate him into penological culture.

Medical forms, for instance, were largely foreign to practicing physicians across the United States in the nineteenth-century. Medical forms did not begin appearing in

American hospitals until the period between 1900 and 1925.[40] During that period, the medical record developed to keep track of the advancing medical technologies in the hospital, specifically tests done on patients including blood count, urinalysis, and x-rays. The medical form, according to medical historian Joel Howell, was one of the era's most important technological developments in medicine. Howell describes the transformation of the medical record from a narrative record to a quantitative medical form. The pre-printed medical form allowed physicians to systematically maintain the results of other developing medical technologies, such as blood pressure and laboratory tests.[41] This transformation of medical record can be seen in the case of Dr. Burton Merrill at Minnesota State Prison. During his tenure at Minnesota State Prison between 1889 and 1910, Merrill maintained a private medical practice in Stillwater, Minnesota. He made a narrative record of his private patients in a notebook, often including references to other family members, and family medical history.[42] In the same years, Merrill kept standardized medical records of inmates at the prison, recording both quantitative medical results on the form while also writing a brief narrative at the bottom of the form.[43]

---

[40] Joel Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995), 2–10.
[41] Christopher Crenner, "Introduction of the Blood Pressure Cuff into U.S. Medical Practice: Technology and Skilled Practice," AIM 128(6) 1998: 488-93.
[42] Notebook of Dr. Burton Jay Merrill, Washington County Historical Society, Stillwater, MN.
[43] Inmate Medical Case Files, 1900-1972. Box 26.C.5.1B-126.C.3.5B. Minnesota History Center, St. Paul, MN; Inmate File, 1870-1910. 125.F.7.7B-125.F.6.9B. Minnesota History Center, St. Paul, MN; Physical Condition Records, 1875-1913. Minnesota History Center, St. Paul, MN; Hospital and Clinic Records. Minnesota History Center, St. Paul, MN. Inmate Records, 1871-1911. Minnesota History Center St. Paul, MN.

The prison physician at Minnesota engaged with quantitative, printed forms for medical recordkeeping as early as the 1850s. The sections of sample forms from 1903 can be seen in Figures 3 and 4.

Minnesota State Prison.

Stillwater.

Name John Richards No. 1012

Alias John Richmond Color White

Received July 14 1903	Age 42 Apparent Age 50
From Itaska County	Height 5–7
Crime Grand Larceny 2nd	Weight 165
Sentence 2 years 2 months	Color of Hair Light
Date of Sentence July 12 1903	Color of Beard +
Trade Laborer	Color of Eyes Light blue
Education poor	Nose
Religion ×	Chin
Nativity English	Complexion
Nationality German	Teeth see Bertillon
Habits Intemperate	Build
Parents Living no	Peculiarities in Build, etc.
Married yes	Marks, Scars, Moles, etc.
Children three	
Remarks	

I, John Richards a prisoner in the Minnesota State Prison at Stillwater, do hereby authorize the Warden of said Prison by himself or his authorized representative to open and examine all letters, papers and other mail matters and all express packages which may be directed to my address so long as I am a prisoner in said Prison.

Dated at the Minnesota State Prison, Stillwater, Minnesota, this 14 day of July 1903

I, J Backland at the Minnesota State Prison do hereby certify that the above and foregoing was read and fully explained by me to the above named prisoner before he signed the same and that he signed the same voluntarily in my presence this 14th day of July 1903

A. Reno
Record Clerk, Minnesota State Prison, Stillwater.

Right thumb here print. To be impressed immediately after signature is written

Special Remarks

Figure 3. Inmate medical intake form from Minnesota State Prison, 1903.

MINNESOTA STATE PRISON

STILLWATER, MINN.

Height 1 m. 673	Head L'gth. 18.8	L. Foot 23.4
" 5 ft. 5 7/8 in.	" Width 15.4	L. Mid. F. 11.7
Outs A 1 m. 75	Cheek " 13.8	L. Lit. F. 9.
Trunk 98.2	R. Ear 6.3	L. Forearm 45.8

Name Chas H. Howard No. 1020
Alias Cheerful Charlie
Nationality American Age 27 Color White
Build Slight Erect Complexion Florid
Hair Dk Ch Eyes Lt ch
Beard Weight 140
Sentenced Apr 1903 Term 3 1/3 Years
From St Louis County for the
Crime of Forgery 2d
Marks and Scars
I sc. inv 1.5x0.2 @ 2d jt L F in
I " " 1x0.2 th L F in.
I " 10.7x0.7 @ 2d jt L F
I " hor 2x0.5 @ 18 ot jt 4
5 v elbow jt in

Occupation Clerk
Corresponds with

F. P. Class

Figure 4. 1903 Bertillon report from inmate medical file at Minnesota State Prison.

Although the form was initially developed for penological reasons to keep track of inmates within the prison system, the physician took advantage of this record to track inmate health and disease across the population and time. Additional pages of the inmate medical record recorded information about birthplace, nationality, crime, sentence, and inmate number, family and clinical medical history including, and a physical examination

that included lab results. He used these basic statistics to prevent disease in the hospital. For example, tracking the number of inmates entering the prison with tuberculosis, and tracking the rate of infection within the prison, led the physician to successfully lobby for an isolated ward for these patients. The wealth of data available through inmate records enabled prison physicians to act as public health doctors/epidemiologists as much as they acted as primary caregivers. Their role required them to care for the institutional health of the prison and the medical characteristics of its population just as much, or even more so, than they cared for individual prisoners, and systematic records gave them the means to do so effectively.

Minnesota's prison system was not alone in recording inmate medical conditions for penological purposes. The National Society of Penal Information published detailed guidelines in the *Journal of Crime and Criminality* for the examination of inmates by physicians.[44] These guidelines were updated regularly, and the procedures were published in seven editions between 1880 and 1905. The examination was comprehensive. It included ten main categories of assessment: general inspection, alimentary system, respiratory system, circulatory system, genitourinary system, cutaneous system, glandular system, nervous system, muscular, and deformities.[45]

---

[44] "The Field of the Prison Physician," *Journal of the American Institute of Criminal Law and Criminology* 5, no. 6 (1915): 921–923; "The Field of the Prison Physician," *Journal of the American Institute of Criminal Law and Criminology* 6, no. 8 (1916): 888–898; "The Importance of and Up-to-Date Medical Department in a Penal Institution," *Journal of the American Institute of Criminal Law and Criminology* 4, no. 6 (1904): 899–904. Some prisons also published their guidelines as recommendations for other prisons. See, for example: "Program for Sociology Course 104. State Care of Dependents, Defectives, and Delinquents in Minnesota," *Journal of the American Institute of Criminal Law and Criminology* 7, no. 2 (1916): 304–306.

[45] An eleventh category was added in the early years of the twentieth century: mental assessment. The physician routinely performed this until 1908, at which time a newly hired psychologist

At Stillwater, the physician performed the examinations that produced these records in the prison's medical facilities. The examination began with an interview of the inmate, covering personal and family medical history. Inmates were also questioned about their drug, tobacco, and alcohol use. The physician then asked the inmate patient to strip in order to assess the whole body. The physical inspection of prisoners included a record of physical characteristics, including eye color, height, and, a statement of the overall quality of health (i.e. physical strength, overall appearance, etc.).[46] Of paramount concern was any sign of contagious diseases, as infections spread rapidly through the inmate population because of the close living conditions. The inmate was then graded into one of three groups according to his or her state of health: good, fair, or poor. These classifications were not made purely from a medical standpoint, but also reflected the physician's assessment of the inmate's ability to work with respect to the existing prison industries, including consideration of the individual's previous occupation and special expertise. The National Society of Penal Information estimated that, on average, 78% of inmates nationwide were diagnosed as being in "good" health, 14% in "fair" health, and 8% in "poor" health.[47]

---

performed the mental assessment of incoming inmates. See: "Assessment of Inmates by the Physician," *Journal of the American Institute of Criminal Law and Criminology* 2, no. 3 (1910): 921–923.

[46] At the same time, the prisoner was measured according to the Bertillon System, which, although concerned with the body and performed by the physician, was used a way to identify inmates, a precursor to the fingerprint system. According to Alphonse Bertillon, a French police officer and biometrics researcher, no two persons were exactly alike in physical measurements. He postulated that any individual could be identified from thousands of others by his cleverly thought-out system. An example of the Bertillon form from Minnesota State Prison, filled out by the prison physician, can be seen in Figure 4. Alphonse Bertillon, "The Bertillon System of Identification," *The Forum* 11 (1891): 330–341.

[47] "The Field of the Prison Physician," (1915) (ref. 44).

In addition to performing physical examinations upon entry, the physician was responsible for the day-to-day care of the inmates, and his systematic approach to the intake evaluation carried over into his quotidian practice. Until 1892, the prison physician was a part-time employee of the prison. The procedure for handling the problems of illness in the prison revolved around the periodic visits of the physician, so effective recordkeeping gave him an advantage.[48] On the days he was to visit the prison, the convicts who were ill reported themselves unfit for duty and were allowed to remain in their cells until sick call. At that time, they were sent to the dispensary for examination and treatment. The very ill were sent to the on-site medical facilities, the less ill went back to their cells, and those who were ill but fit for duty went back to work. The location of inmate convalescence is noted in individual medical forms alongside the physician's diagnosis.[49]

These records indicate that the prison physician, more so than a private doctor, was responsible for a *population*. Doctors in private practice in the nineteenth and early twentieth centuries focused on the individual, but inside the prison the physician was charged for caring for the collective. He had to know the population's collective characteristics and keep a high proportion of them fit to work. This resulted from the

[48] At this time, the prison physician at Minnesota State Prison was an associated administrator. The original act governing the state prison provided for a doctor as one of the officers of the prison. He was appointed by the Board of Inspectors and held office during their favor. He was always a local physician who made periodic calls at the prison and was on call in case of emergencies. His routine on duties included keeping individual medical care records on such maters as the cause for his attendance to prisoners and the outcome of their indisposition. He was also responsible for the inspection of the institution. The prison doctor was assisted in his duties by an inmate until 1877, at which time a civilian was hired to act as a hospital steward. This arrangement continued throughout the balance of the period under consideration.

[49] Inmate Medical Records. Minnesota Historical Society, St. Paul, MN.

conditions that emerged from confinement, and this meant that he often paid more attention to general than personal wellbeing. Medical records, which began as administrative tools of the prison and evolved into treatment and diagnostic tools, allowed him to carry out this role effectively. As discussed in the next section, the physician often encountered situations where his responsibilities to the individual and his duties to the population came into conflict.

Dual Responsibilities of the Prison Physician at Minnesota State Prison

Daily examinations often presented the prison physician with a difficult choice unique to the environment in which he practiced. Many prisoners sustained obvious injuries as part of their participation in the prison industries or suffered from common and easily diagnosable diseases, but others reported symptoms that did not submit easily to testing or verification. Although the physician felt it his duty treat all inmate patients with equal care, he also knew that any claim of illness had to be evaluated as a possible hoax. The prison hospital offered a welcome respite from the rigors of labor and the physician knew that the more devious among his charges were not above exploiting the goodwill he held towards them as a healer.[50] In these situations, the physician was forced to balance individual treatment with his obligation to maintain the health of the prison population and prison industries.

Whenever a prisoner had a reasonable medical complaint, he was typically given the benefit of rest. As a result, malingering by patients was a persistent problem in the

[50] G. Frank Lydston, "Malingering Among Criminals," *Journal of the American Institute of Criminal Law and Criminology* 2, no. 3 (1911): 386–388.

prison setting, something that physicians in hospital or private practice would rarely or never experience. Despite this fact, there was no universal test the physician could use to diagnose malingering. Making an effective judgment about whether or not a prisoner's complaint was genuine often required exceptional creativity. For example, in 1894 an inmate, Mr. A, complained that the entire lower part of his body was paralyzed and that he was unable to walk. He was given a pair of crutches and put in the hospital ward, where he lived well, his wants supplied by the attendants and where he had absolutely nothing to do. Dr. Merrill suspected that he was faking and secretly applied tests to verify his beliefs. The man, however, was on his guard and well acquainted with the standard procedure employed to test such cases. He stood these tests unflinchingly. They included painful skin tests and a drop-test where the physician stood the inmate over a chair and let him go, checking to see if he would engage his legs to break his fall.

The warden took interest in his case and evolved a plan that the inmate had not considered. The strategy was this: A newly appointed guard was dressed in a third grade suit of convict clothes,[51] as seen in Figure 1, on the day when the prisoners were given their weekly shave.[52]

---

[51] All inmates entered the prison as second grade inmates. With good behavior, an inmate could earn first grade status, which entitled the inmate to more privileges in the prison. Inmates with poor behavior were demoted to third grade status, and would loose privileges. For a more detailed description, see Appendix H. *Inmate Handbook*, (Stillwater, MN: The Mirror, 1915); "General Rules" in *Nineteenth Biennial Report of the Minnesota State Prison (1915–1916)* (Stillwater, MN: The Mirror, 1917), 101–108.

[52] Defined by the Auburn system, prisoners were separated and clothed to reflect his/her level of criminality. Those in higher ranking grades, i.e., who had committed less severe crimes, were often assigned jobs with more individual responsibility. See: Elmer R. Akers, "Classification in the State Prison," *Journal of Criminal Law and Criminology* 34, no. 1 (1943): 16–25.

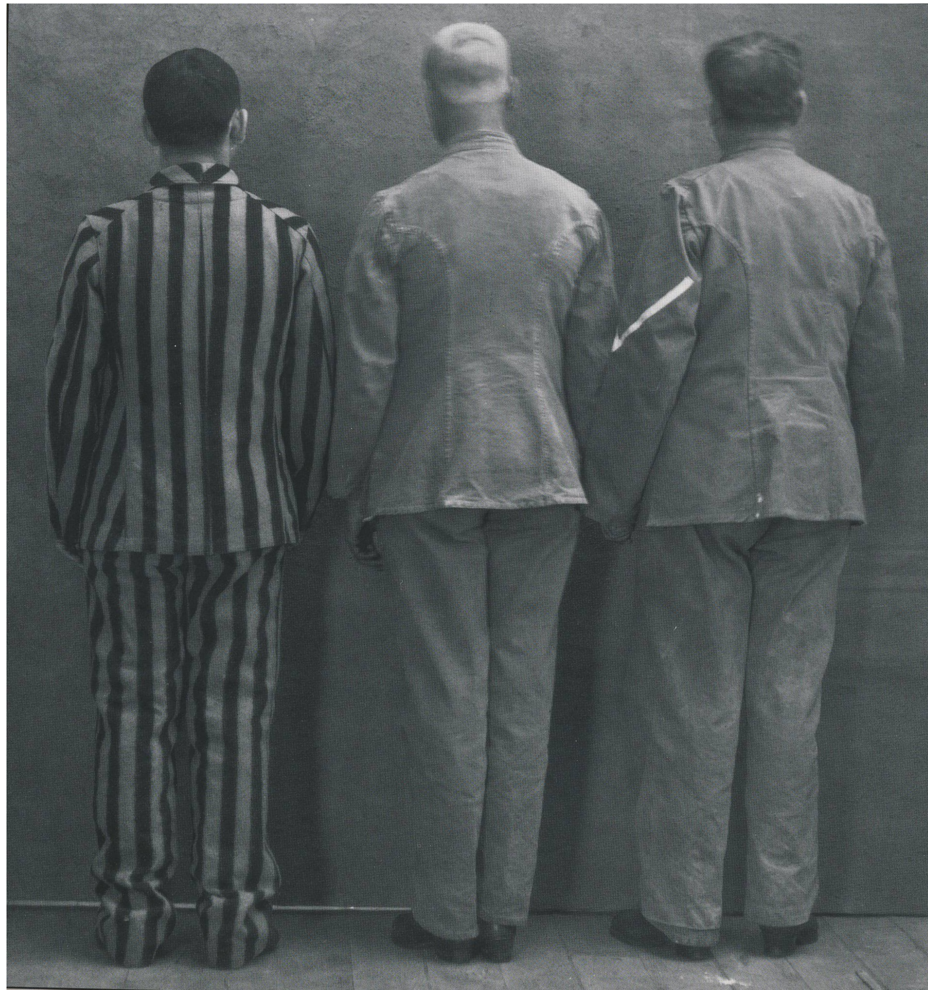

Figure 5: Three classes of prison uniforms at Minnesota State Prison at Stillwater, grade three to one (left to right), photographed 1905.[53]

Mr. A was sitting on the bench waiting to be shaved. The deputy warden stepped into the room with the allegedly lower-ranking prisoner and gruffly ordered him to be seated, then turned to the barber and told him to shave the third-grade man next, as he was in a hurry. In the door leading into this ward, a small peephole was arranged, enabling the guard to look into the room without entering; the warden was stationed behind this door to observe the results of this scheme. As the third grade "prisoner" sat down to be shaved, he

[53] "Inmate Uniforms," Minnesota State Prison Photograph Collection, 1875–1915, Minnesota Historical Society, Saint Paul, MN.

suddenly seized one of the barber's razors, jumped out of the chair, and lunged at the "helpless" Mr. A, who immediately cast aside his crutches and rushed down the corridor to escape from the demented "prisoner," his supposedly paralyzed legs entirely forgotten.[54] At this point, the warden entered the room and informed the crestfallen Mr. A that the comedy was over. At first Mr. A was inclined to continue the paralytic farce, but when informed that he had the option of going to work or taking an indefinite stay on a bread-and-water diet, he choose the first alternative; for the remainder of his term he gave no more trouble.

Of course, not all cases of malingering were so dramatic. Some inmates inflicted minor injury upon themselves to avoid punishment. On September 15, 1885, an inmate, Mr. B, was found by a prison guard in his cell in a pool of blood. Dr. Pratt was called in to evaluate the inmate. It appeared, at first, that Mr. B had cut his throat, but upon further examination, the physician assessed that the blood was coming from the inmate's nose. Dr. Pratt treated the inmate for a self-imposed facial contusion and the inmate remained in his cell. The next day, Mr. B was again found lying in a pool of blood in his cell. Again, Dr. Pratt discovered that the source of blood coming from the nose. Dr. Pratt backed the nasal passageway with rolled cloths and left the inmate to rest in his cell.[55] Warden Reed reasoned that the inmate had self-imposed the facial injuries. He wrote, on September 19, 1885: "[Mr. B was] found at 8 a.m. lying on the floor of his cell, with blood pooled around his head, neck, and shoulders. In my opinion, it was a scheme to get

[54] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN, 114.A.14.1, Box 3.
[55] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN, 114.A.14.1, Box 2.

over the punishment of solitary confinement."[56] Despite his best efforts to avoid punishment, Mr. B was sent to a solitary cell, where the guard was to check on him every twenty minutes.[57]

In at least once case at Minnesota State Prison, an inmate attempted to sham an illness in order to stay *in* prison. Mr. C was discharged by the Minnesota State Prison administration in April 1899. On his last day at the prison, Mr. C spoke with difficulty and appeared to have difficulty walking, according to the physician.[58] Dr. Merrill, Dr. Pratt's successor, ordered Mr. C to eat if he was to be discharged that day.[59] Mr. C refused. The inmate was sent to the prison hospital, despite his scheduled release. The warden "believe[d] that a great deal of his infirmity was put on," but elected not to act on his suspicions, concluding: "It is hard to say how much."[60] Mr. C stayed in the prison under the care of the physician, treated from his cell. He was eventually discharged, six months later than scheduled.

The records of the warden and physician at Minnesota State Prison indicate that tactics, such as those employed by Mr. B and Mr. C, were passed among the prisoners.

---

[56] Warden's notebooks, 1888–1889 and 1890–1912, Washington Country Historical Society, Stillwater, MN.
[57] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN, 114.A.14.2, Box 1.
[58] Warden's notebooks, 1888–1889 and 1890–1912 Washington Country Historical Society, Stillwater, MN.
[59] Burton Jay Merrill was born in Palmayra, IA in 1856, the son of Philo and Sophia (Woodward) Merrill. He graduated from Iowa College in Grinnell, IA and to studied medicine at Bellevue Hospital Medical College in New York, where he had earned his medical degree in 1881. The same year, he married Cornelia E. Merrill of Hudson, WI and practiced medicine in Hudson, WI for one year before starting a practice in Stillwater, MN in 1882. Marquis, ed., *The Book of Minnesotans* (ref. 27), 349–350.
[60] Warden's notebooks, 1888–1889 and 1890–1912, Washington Country Historical Society, Stillwater, MN.

Dr. Merrill wrote in his records in 1893: "Simulated disease is very frequent [in the prison]. [Inmates] feign rheumatic fever by tying tight their hands, or leaning their arm over the edge of the bed until it swells."[61] In an entry one month later in October 1893, Dr. Merrill wrote: "Eight prisoners were brought to me last week with vomiting and diarrhea. At first, it appeared as cholera or intestinal illness. Three of these men confessed that it was done by placing tobacco chews in the fundament."[62] Warden Wolfer conferred with the physician. His report to the Minnesota State Board of Control indicates that malingering was becoming a regular disciplinary problem, not merely a medical problem: "...cases of simulated disease are frequent: he [the physician] has noticed self-inflicted injuries by prisoners, especially to the face and legs."[63]

Diagnosing malingering was not taught in American medical schools at the end of the nineteenth-century; it was a skill that the prison physician learned in his clinical practice at the prison or perhaps as a military physician during the Civil War. Physicians at Minnesota State Prison thoroughly evaluated inmates complaining of sickness or pain, while at the same time looking for social and behavioral signs of malingering. In some instances, the physician would evaluate inmate-patients up to three times per day. Detecting malingering, though, often extended beyond the prison physician, as evidenced in the case of the "paralyzed" Mr. A. In the case of Mr. A, the warden, the barber, the

---

[61] Medical Notebook of Burton Jay Merrill, September, 1893, Washington Country Historical Society, Stillwater, MN.
[62] Medical Notebook of Burton Jay Merrill, October, 1893, Washington Country Historical Society, Stillwater, MN.
[63] Warden's notebooks, 1888–1889 and 1890–1912, Washington Country Historical Society, Stillwater, MN.

physician, and three guards were employed to test the mobility of the supposedly paralyzed prisoner.

This was a definitive aspect of the physician's role in the prison, and at the same time created a tension between his obligations as a primary care physician and his role as a prison administrator. As an administrator, he was a disciplinarian, responsible for enforcing prison rules and helping to keep the prison industries running. Efforts to stem malingering ran the risk of denying treatment to patients who needed it. Despite efforts to responsibly diagnose all genuine physical and behavioral ailments, physicians would occasionally misdiagnose malingering by inmates. In October 1867, for example, an inmate, Mr. D, reported to sick call complaining not of illness, but rather that he was simply "unable to work."[64] On February 4, 1867, Mr. D refused to work. Dr. Reiner made no medical diagnosis.[65] Later in the month, Mr. D collapsed while working in the prison farm machinery shop. Dr. Reiner evaluated Mr. D and assessed that he was "not fit to work" and assigned him to the prison hospital.[66] Two days later, on February 8, the prison physician recorded that Mr. D was "in a very critical state."[67] On February 9, Dr. Reiner reported that Mr. D was "in a dying state."[68] Mr. D died the next day. Mr. D,

---

[64] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN.,114.A.14.1, Box 2.
[65] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN, 114.A.14.1, Box 2.
[66] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN, 121.A.14.2, Box 1, Bound Ledger 1.
[67] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913. Minnesota Historical Society, Saint Paul, MN. 114.A.14.1, Box 2.
[68] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN, 121.A.14.2, Box 1, Bound Ledger 1.

presumably, suffered from an intestinal disease; the physician listed diarrhea, sweating, and abdominal pain in the patient's medical file.

Mr. D was well cared for once he was admitted to the prison hospital. He was given a diet of chicken broth, bread, and vegetables. He was ordered to rest in his hospital cell and relieved of all work duties. He was instructed to walk the corridor for exercise. Dr. Reiner met with Mr. D at least three times per day during his stay in the prison hospital, more than any other patient during that month.[69] Perhaps the physician was attempting to correct his initial mistake of sending Mr. D back to work upon his first presentation at sick call that month. It seemed that the physician felt remorse for his initial misdiagnosis, which is reflected in the level, quality, and quantity of care Mr. D received after being admitted to the prison hospital, similar to the remorse felt by Dr. Pratt in the 1888 case discussed in the Introduction.[70]

In addition to the difficult task of diagnosing malingering in the prison, the physician also encountered the confounding problem of diagnosing inmates with real or feigned insanity. Prisoners feigned insanity in hope of being placed in an asylum, where escape was believed to be easier because of lenient security. The prison was not physically or medically equipped to manage and treat inmates suffering from insanity in the nineteenth-century, but the asylum could not offer the same level of security to contain a criminal inmate. Without proper security, criminals placed in state asylums

---

[69] Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN. 121.A.14.2, Box 1, Bound Ledger 1.
[70] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN, 114.A.14.1, Box 2.

could put other patients and staff at risk of harm.[71] The physician was faced with a decision that forced him to balance patient care with maintaining the health and wellbeing of others.

Before the establishment of asylums for the criminally insane in 1906, inmates diagnosed with insanity were either sent to a state asylum or kept in the prison. The majority of patients at Minnesota State Prison were subject to the latter. The physicians found this policy problematic, as there were not sufficient spaces to house and care for insane criminals within the prison structure. Dr. Lambert wrote, in 1875: "If lunatics are to be confined [in the Minnesota State Prison]...places suitable for their case must be constructed."[72] His concerns were financial as well as medical—some insane inmates were inappropriately confined in prison at an unnecessary expense to the state and to the detriment of other inmates and the prison did not have the appropriate staff to care for insane inmates. Some inmates were sent to asylums, from which they escaped, costing the state between $500 and $1000 for search parties.[73]

Both the prison physician and the warden were concerned with the diagnosis, treatment, and placement of inmates with insanity. This is exemplified in the case of Mr. E, whose actions demanded the attention of Dr. Merrill, Warden Wolfer, and the Board of Control. Mr. E was sent to the state prison in Minnesota for an indeterminate life

---

[71] See Chapter 5 for a more thorough discussion of this topic.
[72] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913, Minnesota Historical Society, Saint Paul, MN. 114.A.14.1, Box 2.
[73] *Sixteenth Biennial Report of the Minnesota State Prison (1909–1910)* (Stillwater, MN: The Mirror Office, 1910), 67.

sentence after a murder conviction in 1900.[74] From the time of his entrance, Mr. E plotted and attempted his escape. On April 15, 1905, he reported at regular sick call, successfully feigned illness, and gained permission from Dr. Merrill to walk the corridors for exercise to promote health. After doing so, Mr. E obtained civilian clothes from the laundry facility and made his escape from the prison, only to be recaptured shortly thereafter at a cost of $1000 to the State of Minnesota.[75] Later that spring, Mr. E again complained of sickness during a daily sick call. Dr. Merrill examined him repeatedly, but was not able to diagnose any real disease.

Foiled in his attempts to sham illness again, Mr. E cut a gash across his wrist that was deep enough to expose the artery, but not deep enough to pose any life-threatening danger. Several times after that he made apparent attempts on his life, each time being careful not to severely jeopardize his physical health. Failing to convince the physician he was sick or injured, Mr. E attempted to be transferred from the prison hospital to the state asylum, where escape could be secured with greater ease. To this end, Mr. E howled in his cell each night with the intention of keeping the other inmates from sleeping, hoping that by making enough of an intolerable nuisance, that he would be transferred. He was transferred, but not until 1911, after the Minnesota established an asylum for the criminal insane in St. Peter, Minnesota.

Another prominent case occurred at Minnesota State Prison between 1894 and 1898. An inmate, Mr. F, was convicted of Arson in the 3rd degree and Assault in the second degree and sent to the Minnesota State Prison to serve a 25-year sentence

---

[74] Inmate Medical Case Files, 1900–1972, Box 26.C.5.1B-126.C.3.5B, Minnesota Historical Society, Saint Paul, MN

[75] Wardens Notebook, Washington County Historical Society, Stillwater, MN.

beginning in 1894.[76] Upon his entry to the prison, Dr. Merrill assessed Mr. F and wrote that he was in good physical and mental health. His rating earned him a highly desirable position in the twine factory at the prison.[77] The warden reported in 1894 that the twine factory guards described him as "quiet" and with "a strong work ethic."[78] There Mr. F worked for two years with superior reviews from the supervising guards.

In October 1895, Mr. F entered the prison yard for daily exercise with his inmate peers. He strolled the perimeter of the yard unaccompanied by other inmates. Unbeknownst to prison officials, Mr. F had been collecting scraps of twine from his position in the twine factory and keeping them in his prison jumpsuit. In the prison yard, Mr. F collected scraps of wood and perhaps even had donations from inmate colleagues who worked in the prison machinery factory. He tied them together with his twine scraps. Mr. F placed the ladder on the exterior wall of the prison and climbed over to freedom. His actions must have been quick, as the warden reports indicate the ladder was found after all inmates returned to their cells. Mr. F was captured just a few hours later skipping rocks on the St. Croix River only a mile from the prison. He was returned to the prison at little cost to the state.

Upon his return to the prison, Mr. F was assigned to work in the prison laundry facility as part of his punishment for his actions. Again, he took advantage of his work situation to assure a second escape from the prison. The laundry staff at the prison was

---

[76] The term was set to an indeterminate sentence with a maximum sentence dictated by the judge at 25 years. Minnesota State Prison (Stillwater, MN), Inmate Medical Case Files, Minnesota Historical Society, Saint Paul, MN. 121.A.14.2, Box 1, Bound Ledger 3.

[77] Warden's notebooks, 1888–1889 and 1890–1912, Washington Country Historical Society, Stillwater, MN.

[78] Warden's notebooks, 1888–1889 and 1890–1912, Washington Country Historical Society, Stillwater, MN.

responsible for washing not only inmate uniforms, but also the clothes of incoming inmates, officers' clothes, and officers' uniforms. Mr. F began his position in the laundry facility without any troubling behavior and was promoted to a line dryer in the facility only six months after his start. There, he was responsible for hang-drying clothes and organizing dried clothes. Mr. F obtained civilian clothes and left the prison without question from the guards. The details of his escape remained unknown to prison officials. He was again found less than a mile from the institution. After each escape, Mr. F was found close to the prison, almost as if he wanted the police to find him.

Dr. Merrill interviewed Mr. F upon his return to the prison for the fourth time in 1897, when he diagnosed Mr. F with "questionable mental intellect." The physician ordered Mr. F to be placed on permanent stay in the prison hospital, which may very well be what Mr. F wanted all along. The inmate refused treatment in the hospital and the physician reported that Mr. F could be heard talking in his cell, which he did not share, each day. On three occasions, Mr. F attempted to harm himself using items in his hospital cell: he cut himself on the metal bed frame, caused contusions by hitting his head, and used his shoelace to asphyxiate himself.[79] On most days, Mr. F also refused food and water. He was transferred to the St. Peter State Asylum in 1898, where he could receive daily, specialized medical attention. Two months after his transfer to the asylum, Mr. F escaped, never to be found.

Mr. F's actions simultaneously demonstrated to prison officials a weak mental character and a nimble, persistent mind. He had the guile to escape from prison, but did

---

[79] Minnesota State Prison (Stillwater, MN), Physical Condition Record, 1875–1913. Minnesota Historical Society, Saint Paul, MN, 114.A.14.1, Box 4.

not have the desire to flee once outside the prison walls. The latter characteristic, combined with his problematic actions in the prison hospital, led Dr. Merrill to diagnose Mr. F as insane. The physician was the only full-time medical staff member at the prison. He did not have the time or training to treat patients suffering from disorders of the mind. Accordingly, Dr. Merrill recommended that Mr. F be transferred to the asylum, where he would receive medical attention that the physician could not offer in the confines of the prison. Mr. F's quick escape from the state asylum, however, indicates that his insanity may have been an elaborate sham.

The physician tried to his best to treat inmates with mental disorders and to diagnose feigned insanity. Reports in crime journals and newspapers indicate an effort around this time to produce an empirical diagnosis for feigned insanity. One such example was published in *The Chicago Tribune* in 1899. The article, titled "Science and False Insanity," describes the work of Dr. Hamilton Deady. At the time, Dr. Deady was the director of the New York State Pathological Institute.[80] Deady claimed that it was possible to determine whether an inmate "acted under order from his brain or the [a] nerve cell combination. Shamming insanity will be useless for a criminal. Medical action will show the truth clearly."[81] His hypothesis proved unfounded and Deady's procedure is not evident in the prison records at Minnesota. Nonetheless, the appearance of this issue in the *Tribune* indicates that malingering was both widespread and well known. Deady's conviction that it could be addressed physiologically indicates that the Stillwater

[80] "Science and False Insanity," *The Chicago Tribune*, March 5, 1899, Part 5, 45.
[81] "Science and False Insanity" (ref. 80), 45.

physicians' tendency to view malingering as medical issue, not just a disciplinary issue, was representative of a larger trend.

The cases of Mr. D and Mr. F exemplify the duality that the physician faced in his daily practice at the prison. Malingering was a matter of disciplinary concern that fell under the province of the prison physician. It was part of his responsibilities as a medical professional to identify malingering and expose it when necessary, often going to great lengths in the process. Malingering was one of the representative factors that compelled Dr. Reiner, the prison physician, and in turn the prison administrators, to conceptualize medicine specifically for the prison environment.

Prisoners showed a remarkable degree of ingenuity and determination in their attempts to deceive physicians in the prison setting. Physicians' efforts to distinguish real from sham illness represented their efforts to appropriately care for their inmate patients, but it was also an extension of their role as disciplinarians. Asking the question and rendering a diagnosis challenged physicians to act not only as a care provider, but also as a prison administrator at the same time. In some cases described above, the feigned insanity and malingering by inmates required both disciplinary and medical intervention. An individual refusing to eat might starve to death or become more prone to illness than the average inmate. A prisoner causing a disturbance would affect other inmates adversely. In dealing with these problematic inmates, prison physicians were forced to delicately balance their parallel responsibilities as disciplinarians and healers.

National Study of Health and Medicine in American Prisons

Nineteenth-century prison reformers focused on the moral and retributive treatment of inmates and the physical conditions of the prison. Despite their focus on inmates, these reformers apparently were not interested in the medical care and physical health of American prisoners. Since medical practice in the prison amounted to the aggregate activities of a set of individuals, mostly local practitioners, it escaped the attention of reformers and their focus on state-dictated aspects of inmate care. Only in the early twentieth century was healthcare in American prisons evaluated at a national level, during a time when Progressive reformers looked to apply rational principles to large-scale social reform. As part and parcel of the Progressive Era reformist impulse, the National Society of Penal Information conducted a nationwide study of medical practice in American prisons.[82] While this study extends beyond the chronological focus of this dissertation, it is nonetheless relevant. First, while the study was published in 1929, it relies on data collected in the previous decades, as early as 1910. Second, it is important to evaluate why a study of this scope did not occur before this period, despite significant changes in penal philosophy and practice led by nineteenth- and twentieth-century reformers. Finally, although it was not completed until 1928, and published in 1929, it

---

[82] The National Society of Penal Information was a prison reform group founded by industrialist and reformer Thomas Mott Osborne. Osborne was appointed as the chairman of the State Commission of Prison Reform in the State of New York in 1912. In 1914 he was appointed warden of Sing Sing Prison in New York. In 1931 the National Society of Penal Information merged with other Osborne-founded social reform organizations to become The Osborne Association. The Osborne Association continues to carry out Osborne's concern for inmates in contemporary society. See: Osborne, Thomas Mott. *Within Walls Being a Narrative Personal Experience During A Week of Voluntary Confinement in the State prison at Auburn, New York* (New York: D. Appleton, 1914); Chamberlin, Rudolph W. *There is No Truce: A Life of Thomas Mott Osborne* (New York: The Macmillan Company, 1985).

reflects social mores that emerged in the preceding decades while American prisons were undergoing rapid development.

National evaluation of medical care for the incarcerated began with a Flexner-style investigation of healthcare in American prisons conducted in 1927 by Frank Leslie Rector,[83] a public health physician, on behalf of the National Society of Penal Information (NSPI).[84] Rector's publication represents the canonical text of health and medicine in America's prisons, much as Flexner's work was the authoritative document on the quality of American medical education at the time. In both cases, these reports

---

[83] Frank Rector was a public health physician, concerned mostly with water and environmental health prior to his to work in American prisons. His concern with environmental health included occupational health and the health of industrial workers. During this time, Rector was a consultant for the Board of Physicians in Industry, where he conducted a study of the physical health of industrial workers in 1922. His report was widely cited in occupational health journals and it earned him a promising reputation within the national medical societies. Rector turned his attention to the health of inmates, a similar study to his study of industrial workers, in 1927, on behalf of the National Society of Penal Information. At the conclusion of his year-long study of medical practice and care in the American prison system, Rector became an advocate for the American Society for the Control of Cancer. Over the next decade, Rector published cancer surveys of ten states on behalf of the society. He also published cancer material for the lay public, including a pamphlet on the cause, diagnosis, and treatment of cancer for high school students. See: Frank Leslie Rector, *Cancer, Cause, Diagnosis, Control* (Pamphlet) (Indianapolis: Indiana State Board of Health, 1937); *Cancer Survey of Colorado* (New York: American Society for the Control of Cancer, 1931); *Cancer Survey of Illinois* (New York: American Society for the Control of Cancer, 1936); *Cancer Survey of Kansas* (New York: American Society for the Control of Cancer, 1933); *Cancer Survey of Michigan* (New York: American Society for the Control of Cancer, 1935); *Cancer Survey of Minnesota* (New York: American Society for the Control of Cancer, 1932); *Cancer Survey of Nebraska* (New York: American Society for the Control of Cancer, 1934); *Cancer Survey of Saint Louis County, Missouri* (New York: American Society for the Control of Cancer, 1931); *Cancer Survey of Wisconsin* (New York: American Society for the Control of Cancer, 1931); *Health Education: Supplement to Committee Report Covering Paper and Discussion at the Pittsburgh Convention, November 8, 1922* (New York: National Personnel Association, 1922); *Hard Water and Health* (New York: A. R. Elliott Pub. Co., 1916); *Physical Examination of Industrial Workers: Results of an Investigation by the Conference Board of Physicians in Industry* (Chicago: American Medical Association, 1920); *The Story of Cancer for High Schools* (New York: American Society for the Control of Cancer, 1933); and *Underground Waters for Commercial Purposes* (New York: John Wiley & Sons, 1913).

[84] Frank Leslie Rector, *Health and Medical Service in American Prisons and Reformatories* (New York: National Society for Penal Information, 1929).

were fundamental in establishing guidelines for quality, suggesting means for reform, and establishing a national standard for medical training and care. This survey style of research was popular during the Progressive era, and was the primary tool of social scientists and social reformers in early twentieth-century America, a form of "social telescope."[85]

The NSPI was aware of deficiencies and inequalities in penal institutions across America, many of which related to the health of prisoners. Rector and the NSPI aspired to use the results of the report to create a new branch of prison administration that would work to improve conditions in prisons and bring about a standardization of health and hospital practices in penal institutions. While not explicitly stated by Rector, the mission and methodology of the prison study were evidently informed by Flexner's medical school census in the first decade of the twentieth century.

Frank Rector surveyed every state and federal prison in the United States between November 1927 and October 1928, a methodology consistent with Flexner's study.[86] In total, one hundred penal institutions were evaluated according the medical survey guidelines.[87] Rector presented his findings in *Health and Medical Service in American Prisons and Reformatories*, published in 1929.[88] Each chapter examined an aspect of care in the prison setting: medical administration, hospitals, physical examination of inmates,

---

[85] Converse, Jean. *Survey Research in the United States: Roots and Emergence 1890-1960* (Berkeley: University of California Press, 1987), 1.
[86] A panel of physicians designed the survey. Members of the NSPI survey committee without institutional healthcare experience were "selected both for outstanding accomplishments in their respective professional fields and as representatives of the great national organizations interested in the problems to be studied." Rector, *Health and Medical* Service (ref. 84), 5.
[87] Rector, *Health and Medical* Service (ref. 84), 15.
[88] Rector, *Health and Medical* Service (ref. 84).

nutrition, dental service, tuberculosis, venereal disease, and mental health. And each included a general ranking, consistent with the evaluation rhetoric that Flexner used in the previous decades. A summary of the findings across all prisons and topics was detailed in extensive appendices.

Rector's analysis of health and medical services in American prisons was generally favorable, but did identify specific places, policies, and practices that were in need of reform. For example, every United States state and federal prison, with the exception of Vermont's, had some type of hospital facility by 1927.[89] In approximately half of the prisons the hospital occupied a separate facility on the prison campus, yet almost none of these had a medical laboratory.[90] Every hospital had an area for pharmaceutical preparation. These facilities varied extensively. Rector cites one prison in New York that had installed equipment for the manufacture of pharmaceuticals.[91] The presence of on-site pharmaceuticals at certain prisons gave these prison hospitals certain capabilities comparable to those of large public hospitals. In the early twentieth century the prison systems of most states across the nation relied on local universities for laboratory work and compounding pharmaceuticals for inmate patients. The presence of on-site pharmaceutical compounding made prison medical practice more autonomous, and offered inmates more timely treatment. While expensive to purchase and install, pharmaceutical machines on-site likely saved the New York prison a significant amount of money over the subsequent decades.

---

[89] Rector, *Health and Medical* Service (ref. 84), 68-72.
[90] Rector, *Health and Medical* Service (ref. 84), 78.
[91] Rector, *Health and Medical* Service (ref. 84), 45

Rector did not identify a uniform system of recordkeeping in prison hospitals.[92] This is to be expected, as early twentieth-century hospitals were only just beginning to enforce strict patient recordkeeping. Minnesota State Prison at Stillwater, however, had an exemplary means of recordkeeping, complete with entry, exit, medical, and labor forms that were filled out for each inmate. The physician, or hospital steward in very few cases filled out these forms to completion. All inmate medical files were kept in the office of the physician on-site at the prison. The physicians at Minnesota used the medical forms to keep basic statistics on inmate health and disease, which inspired preventative public health measures in the prison, such as changes in the physical prison to prevent disease. At the end of each month, physicians tallied vital statistics. This most often happened on a blank medical form at the end of each month, and were often left in in folders with inmate medical records.

Starting in the 1870s, the physician often used these aggregate statistics to his annual report to the governor to lend support to his requests for funds, space, and equipment.[93] For example, Dr. Merrill reported to the governor a high proportion of patients, aggregated from the inmate medical records for the previous months, who experienced respiratory distress after being admitted to the prison hospital. Dr. Merrill recommended that: "new quarters be produced for the hospital department. Our present ward is low, and poorly ventilated, and should it be crowded with sick at any time, the

---

[92] Rector*, Health and Medical* Service (ref. 84), 81
[93] These tallies occur in almost every year of the inmate medical forms, and occur frequently in annual reports. See, for example: W.H. Pratt, "Annual Report of the Physician of the State Prison," in *Annual Report of the Warden of the State Prison* (Stillwater: Prison Mirror, 1876): 237.

bad effect of insufficient space and ventilation would be evidenced at once."[94] In this way, the records were not only treatment tools, facilitating the physician's care of his patients; they were also administrative tools, helping him to advocate for changes in prison structures and procedures.

While the conditions were generally favorable, Rector reported that the prison hospitals were greatly understaffed. Each state had at least one physician assigned to the prison hospital, although many physicians were only part-time employees of the prison. Physicians in most states were assisted by inmates, usually identified as "hospital stewards." The physicians were typically men who had several years' experience in private practice before taking up institutional work. In only a few states were recent hospital graduates found in charge of prison hospitals.[95] In Minnesota, every attending physician in the prison between 1860 and 1930 had a private practice in the town of Stillwater, where the prison was located, in conjunction with assuming medical practice at the state prison.[96]

Rector's work, published in 1927, uses prison data from the 1910s and 1920s, permitting a national perspective on healthcare in the prison at the end of my story's timeline. Since his data comes from a range of prison surveys completed between 1910 and 1927 we also see how care in the prison changed over these decades, and changes in what type of data was collected by state agencies and reform groups. Significantly, no other Flexner-style survey of inmate care was conducted post-Rector. This style of

---

[94] *Fourth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1890* (Saint Paul, MN: The Pioneer Press Company, 1890): 38-39
[95] Rector*, Health and Medical* Service (ref. 84), 112
[96] See Appendix C of prison physicians for a more detailed analysis.

evaluating medical institutions was not unheard of in the early twentieth century. For example, asylums conducted regular surveys about staff. The National Society for Mental Hygiene often conducted similar assays, aiming to examine whether asylums were therapeutic or just convenient dumping grounds for incurables.[97]

Rector's work provides an overview of some of the institutional challenges prisons faced when considering the medical care of their wards. The large-scale institutional characteristics discussed in Rector's report provide the context for the everyday pressures prison physicians faced when exercising their duties. Foremost among these was the contradiction inherent in their role. On one hand, physicians were responsible for the health and wellbeing of inmates. On the other, physicians were prison administrators who are responsible for conforming to the custodial and disciplinary goals of the prison. The Minnesota State Prison physician's daily encounters with inmates in the prison hospital highlight the professional duality of correctional medical practice.

Conclusion

Physicians in American prisons at the turn of the twentieth century held power as prison administrators—they had the authority to order extra punishment, alter diet, and request changes in labor placement. The prison physician, though, understood his primary

[97] In 1909, Clifford Beers, William James, and Adolf Meyer founded the National Committee for Mental Hygiene, previously the Connecticut Society for Mental Hygiene. One of its missions was to improve mental health treatment and care. In order to do so, the society evaluated the current care offered in public institutions, primarily in the northeast region of the United States. See: Mental Health Association in New York State, Inc. Records, 1879-2002, M.E. Grenander Department of Special Collections and Archives. University at Albany, the State University of New York.

responsibility to be the management of inmate health. As a result, he exercised his authority judiciously. Rather than taking punitive action against individual inmates, he usually exerted his influence in an administrative capacity, seeking to control the shape of medicine practiced within the prison walls—and sometimes the shape of the prison walls themselves. In order to care for a confined population, and care for the inmates both individually and as a collective, the prison physicians at Minnesota formed a clinical practice that responded to the physical constraints, population characteristics, and disciplinary aspects of the prison environment.

In reacting to a range of challenges and circumstances involved in importing medicine into the penitentiary system, the physicians at Stillwater crafted a conception of medicine that was tailored to a correctional context. This chapter identifies three primary characteristics of penitentiary practice. The physician overcame issues related to limited space for the care of inmates in the prison, space that was originally designed to confine inmates, not treat them. The physician exercised his role as a prison administrator *and* as a physician to restructure the medical facilities to address the prison's disease environment. The creation of wards for specific diseases demonstrated the institution's commitment to preventing and curing endemic diseases of the prison. The physician cared for individual inmates in this context, but also used the inmate medical records to guide public health measures targeted at the health of the population of inmates as a whole. Malingering had to be addressed within the context of the correctional and rehabilitative aims of the prison. Not only was the physician responsible for the care of prisoners, but he was also the gatekeeper to care for the inmates and a disciplinarian. The

manner in which he balanced these roles was determined, in part, by the demographic characteristics of the prison population, the topic of the following chapter.

Chapter 3:
Prisons, Health, and Hygiene: Health and Disease Demographics of Late-Nineteenth-Century American Prisoners, 1880-1920

Introduction

"The health of inmates of the State Prison for the past two years has been better than could be expected in an institution for this kind, and more especially when we consider the conditions of a large number of convicts sent here," wrote Dr. Pratt in his 1881 annual report to the Governor of Minnesota.[1] The swelling prison population was a central aspect of Pratt's expectations for the condition of the inmates, but his responsibilities also required him to react to the particular characteristics of that population and maneuver within the physical space in which that population was housed. These three aspects—the size of the prison population, its characteristics, and the space in which it was contained, constituted the principal constraints on the physician's practice in the prison. As these factors changed through time, the physician's role evolved with them.

This chapter examines these three strands of historical development and argues that they shepherded prison medicine by providing the elements that made it different from other forms of medical practice. Prison populations swelled between the mid-nineteenth and the mid-twentieth centuries in the United States, both in raw numbers and proportionally. In 1850 the average American prison held approximately 2 inmates for

[1] *Biennial Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Two Years Ending November 30th, 1880* (Saint Peter, MN: J. K. Moore, State Printer, 1881).

every 10000 members of the population; by 1930 that figure had tripled.[2] As the population grew, conditions emerged that made prisoners susceptible to specific diseases and disease trajectories. These trends were exacerbated—and ultimately also addressed by the physician—through the design of the prison itself. By the early-twentieth century, largely in response to the context of practice these trends created, the role of the prison physician had matured, the expertise and responsibilities that set it apart from other medical specialties shaped by the demographic characteristics of the ballooning prison population.

This chapter lays out the issues in caring for a growing inmate population within the prison, with a focus on inmate demographics, including shifts in disease trends, mortality, and prison hospital design. One of the most common diagnoses in the prison was tuberculosis. In addition to treating inmates who entered the prison with the disease, the physician was responsible for preventing its spread within the institution. In doing so, the physician tested new forms of treatment and preventative measures, some more successful than others. For example, the creation of an isolated ward for tubercular patients significantly decreased the rate of infection within the prison. Tuberculosis therefore serves as an exemplary case study with with which to frame this chapter as it illustrates both the individual- and population-level health issues with which prison physicians grappled.

---

[2] Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database] (Minneapolis: University of Minnesota, 2010).

Methods & Materials

This chapter relies upon a combination of institution-level records from the Minnesota State Prison at Stillwater and data distilled from the US Census. The Minnesota State Prison inmate medical case files provide an account of individual health for each inmate. Archival records from Minnesota State Prison include individual case records of infectious diseases, living conditions of inmates, prior and current addictions, sick-call records, and hygienic inspection records. Census data offers a picture of the large-scale demographic features of both the American public and of prisoners across the country. Together, institution-level and national-level data allow for an assessment of Minnesota State Prison's development against the backdrop of national trends.

Data taken from Minnesota State Prison records submit well to quantitative treatment because of the structured nature of prison existence. Medical care, like every other aspect of prison life, was highly regimented. An inmate wanting to be seen by the physician would inform the guard of this request in the morning, before the daily routine started. The guards would bring the inmate to the hospital building (or floor, depending on the year). Upon arrival at the hospital ailing prisoners formed a line outside the door and were called into the physician's office one at a time. While meeting with the physician, the inmate would state his or her name and complaint. The physician would interview and physically examine each inmate. The physician could then determine a treatment and prescribe a diet befitting the diagnosis. Inmate diagnosed as too sick to work would stay in the hospital. In some cases, sick inmates were sent back to their cells

to rest before returning to work a few days later. In a minority of cases, convalescing inmates were allowed to walk the exercise grounds during the day.

The physician recorded all of these interactions in an inmate register, where the inmate entering medical exam records were also kept. The physician commented on these cases in his notebook, often writing about the diagnosis, his thoughts about diagnosis and treatment, and about the outcome of the case. These records are plentiful, as the physician recorded, on average, 818 hospital cases per month between 1880 and 1920.[3] The physician occupied a privileged place in the prison structure. He had the influence of a high-level administrator, enjoying the ear of the warden on matters impacting inmate health, and he also kept touch with the day-to-day of prison life through his continual contact with inmates. As a result, the physician's records offer a powerful tool for assessing changes in medical practice and health of institutional populations in this period.

These records are not without their drawbacks. The medical records kept by physicians in the nineteenth-century are incomplete and inconsistent. Hospitals and state institutions are the richest sources of data about this period. Important questions, such as the relative influence of environment on infectious disease were considered and record keeping was used for this purpose. While these records are consistent—that is they ask

[3] These records have been collected from the Minnesota State Record and linked using inmate number, year of birth, and sex. They include: Inmate Medical Case Files, 1900–1972, Box 26.C.5.1B-126.C.3.5B, Minnesota Historical Society, Saint Paul, MN; Inmate File, 1870–1910, 125.F.7.7B-125.F.6.9B, Minnesota Historical Society, Saint Paul, MN; Physical Condition Records, 1875–1913, Minnesota Historical Society, Saint Paul, MN; Hospital and Clinic Records, Minnesota Historical Society, Saint Paul, MN. Inmate Records, 1871–1911, Minnesota Historical Society Saint Paul, MN. I will refer to this database as Minnesota State Prison Inmate Health Database.

the same questions, use similar shorthand, record physical attributes, et cetera—cause of death is sometimes a problematic entry. Prison records do not always list an obvious cause of death, and the manner of reporting prisoner fatalities varied widely by physician and locale.

Cause of death records have been discussed, and to some extent analyzed, by twentieth-century historical demographers Jeffrey K. Beemer, Douglas L. Anderton, and Susan Hautaniemi Leonard. Anderton and Leonard address issues in cause of death labels through studies of medical registers in Northampton, MA. Jeffrey Beemer also contributes to this discussion, using similar registries from Massachusetts.[4] Together, these authors offer methods of standardizing disease and cause of death terminology for historical demographers using nineteenth-century medical records. Previous to these studies, most historians used the 1900 International Classification of Disease (ICD) offered by the US Census Bureau in 1900, which was a consistent, but less descriptive registry.[5] Anderton and his colleagues offered new ways to interpret cause of death registries, including accounting for social biases, and ambiguous cause of death, and using physician notes and elaboration to interpret the diagnosis. I used these guidelines to

---

[4] Douglas L. Anderton and Susan I. Hautaniemi, "Grammars of death: An analysis of nineteenth-century literal causes of dead from the age of miasmas to germ theory," *Social Science History* 28 (2004): 111–143; Jeffrey K. Beemer, Douglas L. Anderton, and Susan I. Hautaniemi "Sewers in the city: A case study of individual-level mortality and public health initiatives in Northampton, Massachusetts, at the turn of the century," *Journal of the History of Medicine and Allied Sciences* 60 (2005): 42–72; George Alter and Ann Carmichael "Classifying the dead: Toward a history of the registration of causes of death," *Journal of the History of Medicine and Allied Sciences* 54 (1999): 114–132.

[5] U.S. Census Bureau, *Manual of International Classification of Causes of Death* (Washington, D.C.: U.S. Department of Commerce and Labor, 1902).

digitize medical records of Minnesota State Prison at Stillwater, creating a disease classification system consistent with both the ICD and US Census Bureau.[6]

To complement the detailed institutional records, I examine historical census data from 1880 to 1920. These data expose the demographic characteristics of inmates across the United States.[7] This will allowed for analysis and discussion of any regional or temporal differences in inmate demographics.[8] I compared the health characteristics of the Minnesota prison population with the population at large in early twentieth-century America in order to illustrate characteristic set of health concerns and medical challenges within the prison. Additionally, these records contributed to an analysis of the overall health of prisoners.[9]

Combining quantitative insights with individual, qualitative examples exposes how daily life at the prison unfolded while setting that picture in the context of larger disease trends. The example of the treatment of tuberculosis in the prison is a particularly apt case study because it demonstrates the responsibilities of the physician on every scale. He kept detailed reports of individual treatment regimes, and also of his focus on

---

[6] U.S. Census Bureau (1902) *Manual of International Classification* (ref. 5); U.S. Census Bureau, *Mode of Statement of Cause of Death and Duration of Illness upon Certificates of Death* (Washington, D.C.: U.S. Department of Commerce and Labor, 1908).

[7] IPUMS-USA consists of 1% Census samples of the American population drawn from 15 Censuses between 1850 and 2005. Census data from 1880 is also available in a 100% data series. There is no United States Census data for 1890.

[8] This allows for a three-level analysis—population level (census data), institutional level (records of prison), and individual level (stories of individual inmates and doctors).

[9] This study examines the transition of healthcare in the American prison at the turn-of-the century, ending at the conclusion of the Progressive era. The timeframe of this study is partially determined by the availability of records. In most years, the prison physician and administrative bodies left comprehensive notes to supplement existing forms; however, there are some periods where administrative and medical forms are completed without detail or periods where records are missing due to a prison fire.

tuberculosis as an institutional problem. Using a framework that remains attentive to these different scales, I contextualize the stories of individual prisons and prisoners. Of greatest importance, combining sources and two scales allows for a clear quantitative and qualitative analysis of the medical transition of the prison between 1880 and 1920. The quantitative data will show any increase or decrease in health and disease trends, such as the number of inmates classified as mentally ill or deviant, and the archival data will illustrate these trends through individual level accounts.

Inmate Demographics

Minnesota's inmate population mirrors the national growth trend between 1850 and 1930. This growth does not merely track the increase in overall population; incarceration rates show a similar trend to the frequency growth, suggesting that analysis of social factors must be examined to understand this trend. For example, the inmate total peaks in 1930, at a time when the Volstead Act effectively expanded the definition of crime. The population of American prisoners was predominantly male, never dipping below 70%.[10] Women's prisons first became prevalent in the United States in the 1910s, so the impact of the creation of such institutions cannot be seen here. Here again Minnesota is representative of the nation as a whole.[11] Minnesota State Prison can, therefore, be considered broadly representative in many of its demographic patterns and characteristics. Before considering those large-scale factors, however, I turn to the quotidian routine of prison medicine.

---

[10] Minnesota State Prison Inmate Health Database (ref 3).
[11] Ruggles, et al. *Microdata Series: Version 5.0* (ref. 2).

Each day, convicts who were ill reported to the physician, who categorized them in one of three groups: 1) sick, but able to work, 2) sick, and to remain in cell, or 3) sick, and admitted to prison hospital. The physician's records of inmates' self-reported medical conditions appear in the hospital sick call register. These records provide a suitable description of health, disease, and care of the prisoners.[12] These records document an individual's long-term medical history and can be used as an indicator of overall health in the prison.

In the early years of the prison, the average inmate appeared for sick call about eight times per year. The only comparison to sick-call rates in American prisons is with American military hospitals of the period; military hospitals shared similar structures and challenges of prison hospitals. According to Paul Starr in *Social Transformations of American Medicine*, the average serviceman visited the hospital about three and a half times per year in the nineteenth-century.[13] Both military and prison inmate patients probably saw benefits in visiting the hospital, as it prevented them from working on serving military duty. The confinement of prisons, though, led to greater rates of infectious disease among inmates, which helps account for the higher rate of hospital use seen in the prison. Paul Starr notes that the average American in the nineteenth-century "seldom called the doctor." This was likely due to economic factors; a doctor's presence was a luxury for most middle class families, but a factor that most inmates did not have to concern themselves with while confined in a state institution.

---

[12] Minnesota State Prison Inmate Health Database (ref 3).
[13] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Book, Inc., 1982), 154.

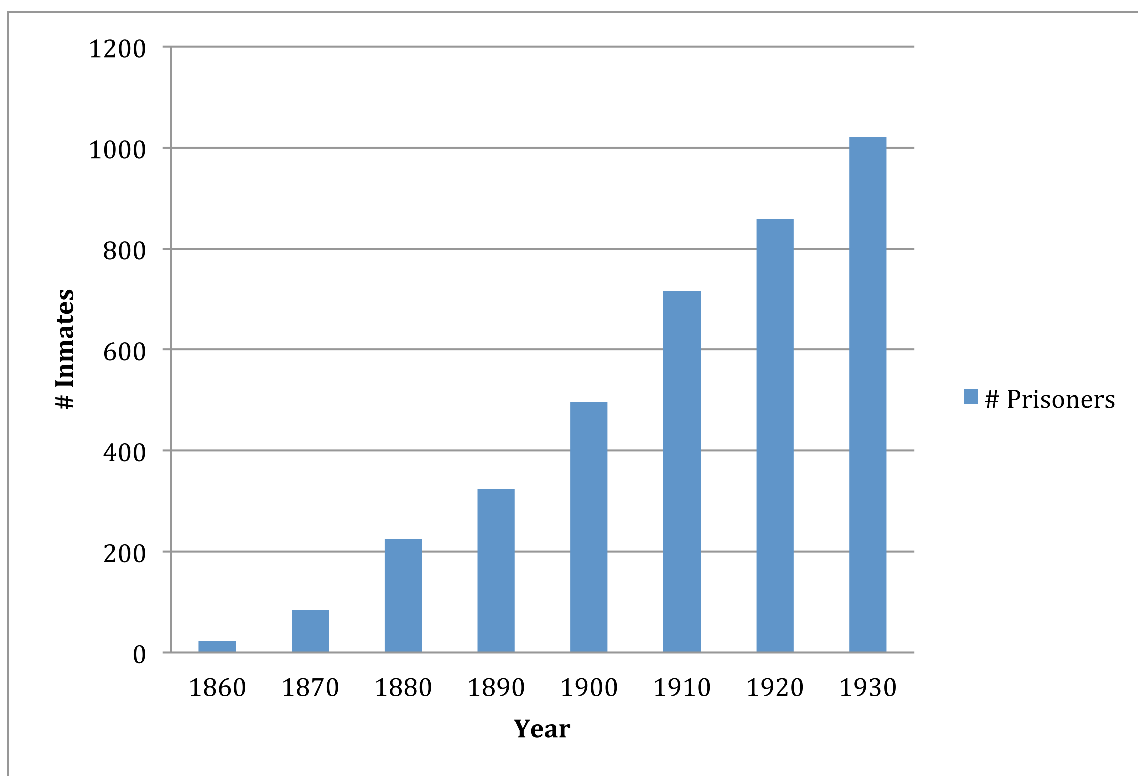

Figure 6: Number of Inmates at Minnesota State Prison by Year, 1860-1930.

Interactions between doctors and patients within Minnesota State Prison were profoundly influenced by the large patient-to-doctor ratio in the early twentieth century. The Minnesota State Prison at Stillwater's inmate population absorbed new inmates at a higher rate every year between 1851 and 1920. For example, in 1880 there were 155 admissions to the state prison.[14] Thirty years later in 1910, admissions nearly doubled to 332. The rise in admissions was not accompanied by a similar rise in discharge, so the total resident population increased rapidly. Between 1850 and 1930, the prison inmate population of Minnesota increased from 22 to 1,330.[15] This spectacular growth was due

[14] Minnesota State Prison Inmate Health Database (ref 3).

[15] Minnesota's state institution population reached its zenith in 1959 with a total of 12,489 inmates and patients. The resident population at the State Prison peaked in 1956 with a total of 4,

in part to a boom in state population as immigration to the expanding western territories increased, but the rates of incarceration, shown by rate per 10,000 of general population in Figure 7, show an additional proportional increase.[16] Despite some fluctuations with declines after the American Civil War, World War I, and a rise at the start of the Great Depression, the rate averaged around 30 inmates per 10,000 of the general population throughout this period.[17]

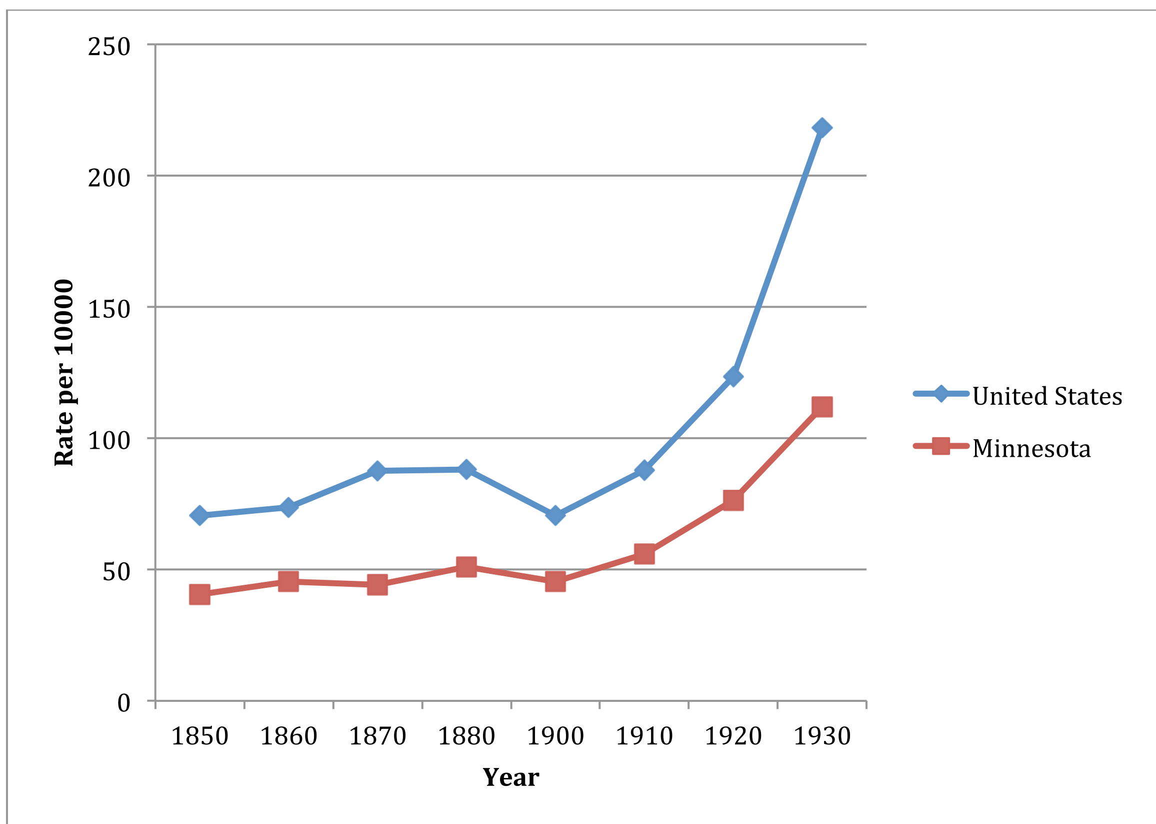

Figure 7: Incarceration rates in the United States and the State of Minnesota, 1850-1930.

878 patients. See: Minnesota State Institutions, Biennial Reports to the Board of Control, Minnesota Historical Society, Saint Paul, MN

[16] Minnesota State Prison Inmate Health Database (ref 3).

[17] Minnesota State Prison Inmate Health Database (ref 3).

As seen in Figure 8, the three greatest diagnoses of patients by the physician in the prison hospital were physical injury, unexplained illness, and infectious disease.[18] Figure 8 represents the classification of medical diagnosis of prison inmates by the prison physician by year. Each disease is shown as a proportion of total number of diagnosed patients by year. This graph was constructed from data of the daily reports of the prison hospital, as reported by the physician.

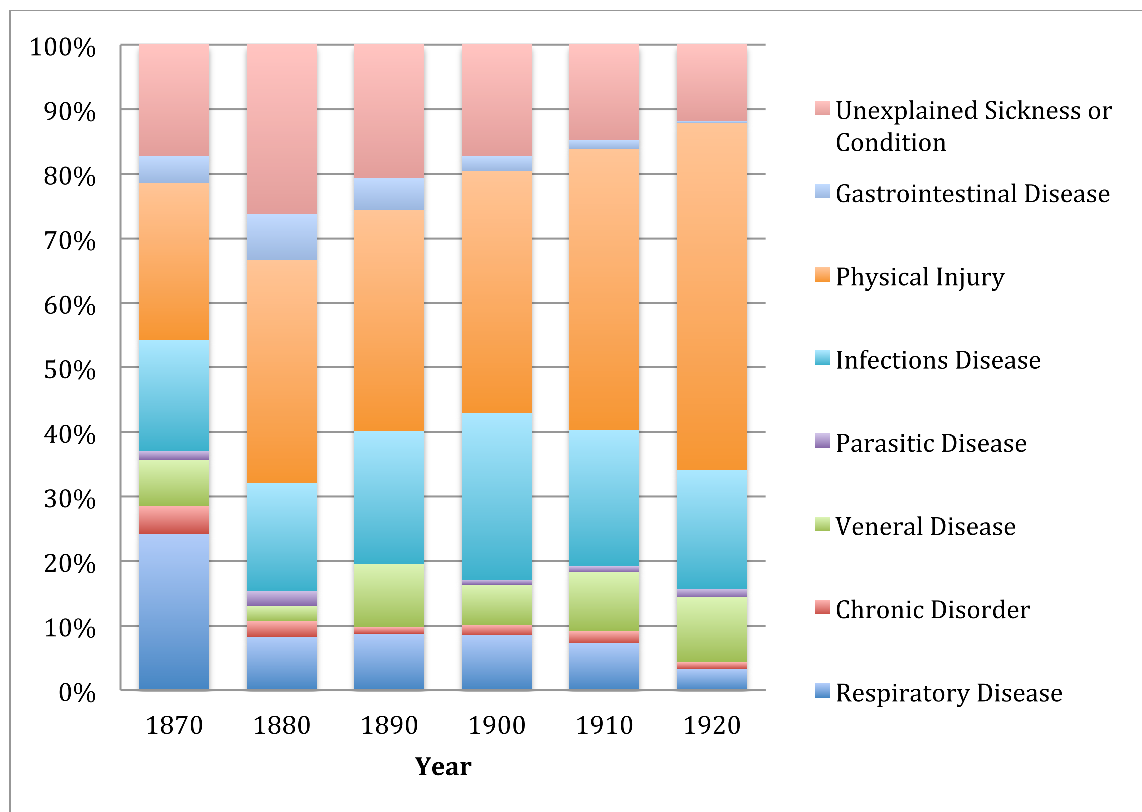

Figure 8: Frequency of inmate disease diagnosis by the prison physician at Minnesota State Prison, 1870-1920.

The disease profile of the prison population that emerges from the physician's reports lies in stark contrast to the health of the prison population described in the 1880

[18] Daily register of the prison hospital, 1851–1925. Box 154.4.1a. Minnesota Historical Society, Saint Paul, MN.

census. In 1880, the US Census included a question about sickness: “Is the person (on the day of the enumerator's visit) sick or temporarily disabled, so as to be unable to attend to ordinary business or duties? Is so, what is the sickness or disability.”[19] The health profile of the inmate population of Minnesota is presented alongside the sickness profile of the general population in Figure 9. One word of caution when viewing this is that US Census represents a very small number of individuals. The missing cases were removed in order to highlight the ailments of those who did report a sickness. Also, this graph includes only male respondents, to make it more comparable to the inmate medical data from Minnesota state prison which is almost entirely male. This also reduced the total number of cases, and leaves a significant room for error.

The US Census is a portrait of the nation taken through the lens of one day. Because of this, the rate of sickness varies from that of the prison hospital, showing a higher rate of chronic disease. Acute diseases, such as bronchitis or infection, occur for a short period of time, thus making them harder to capture accurately in the US Census. Rates of acute disease are higher in the prison hospital, as the numbers reflect each day of treatment in a medical facility during the course of a year. It is to be noted, too, that the rates of infectious disease, unexplained illness, and mental disease are high within the census report, likely because of the type of disease indicated. Additionally, most mental diseases represented here are not acute or temporary, but rather persistent, chronic afflictions. Additionally, the census question is meant to describe sickness that prevents and individual from carrying out everyday activities. In case of the prison, the decision of

[19] 1880 Census Ennumeration From, accessed through IPUMS. Ruggles, et al. *Microdata Series: Version 5.0* (ref. 2).

whether an inmate was capable of performing daily labor fell to the prison physician. In very few cases were inmates excused from daily labor. The different standards applied by the prison physician and census enumerators means that many minors diseases and injuries are likely underreported among the prison population when compared with the population at large.

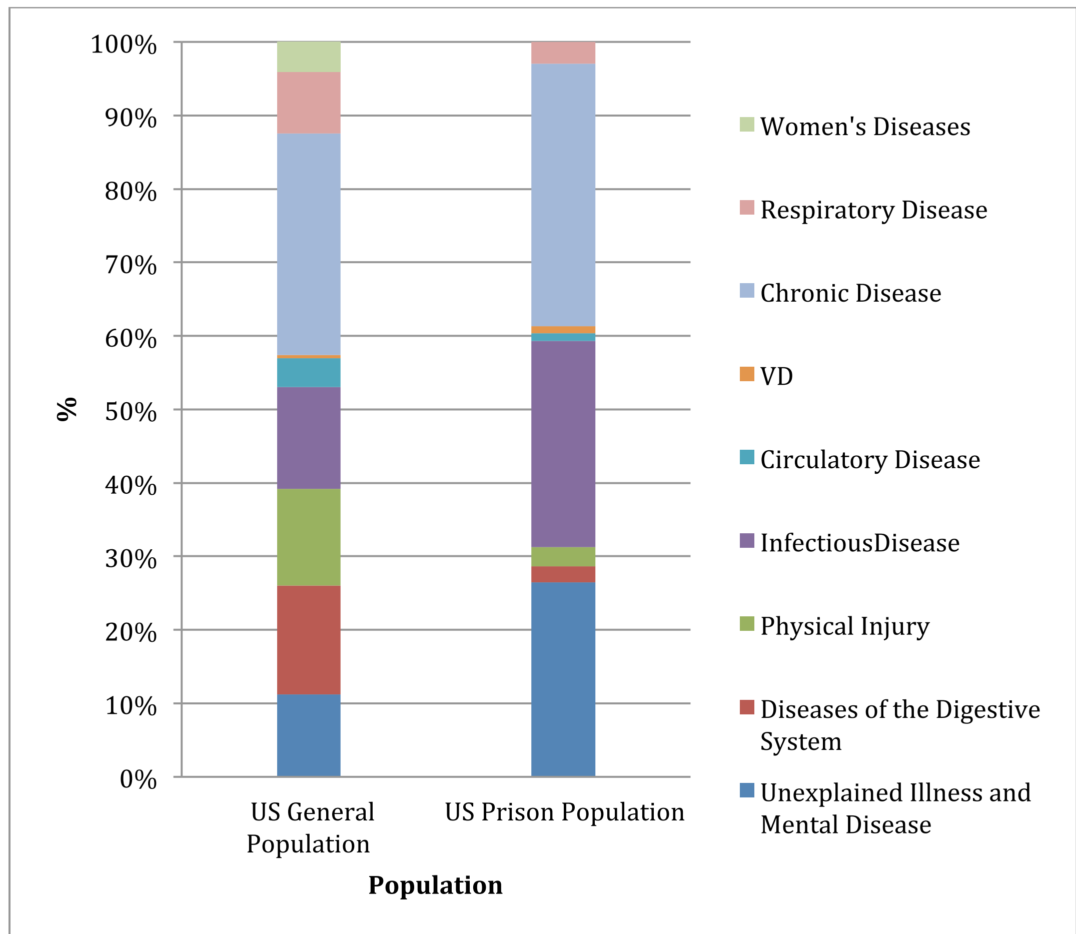

Figure 9: Reported sickness of the general public, reported in the US Census, and of the inmate population of Minnesota.

According to the hospital records, most prisoners reported "pain" or "illness" as their reason for attending sick call. A large number of prisoners experienced physical

injury, as seen in Figure 8.[20] Most injuries were attributable to work at one of the industries on site—initially a repair shop and a metal shop. Rates of external injury coincided with the development of additional industry at the prison. When the new prison was established in 1912, it brought with it a twine factory, a farm machinery factory, a mechanical repair shop, and a metal shop. A high rate of injury was common for these occupational positions and environments.[21]

Infectious disease rates, reflected in Figure 8, were also high, largely explained by the close proximity in which inmates lived. These rates do decrease slightly by the early twentieth century, as they do for the nation as a whole. By this time, the physician, understanding the new germ theory of disease, recognized the rapid rate of infection that occurred within the prison and attempted to isolate prisoners in a small infectious disease "ward" to reduce transmission. This ward was the size of one cellblock corridor and was only equipped to contain a small number of inmates actually infected. As the data show, this measure had only a marginal impact in the rates of infectious disease within the prison.[22]

Particularly striking about this graph is the rate of unidentified or unexplained sicknesses or conditions. This rate, in part, accounts for prisoners who claimed to be suffering from conditions that were difficult or impossible to test for. As discussed in Chapter 2, prisoners would feign illness, insanity, even attempt suicide, in order to escape the full rigors of the prison regimen. Some of the unexplained conditions can therefore be

---

[20] Minnesota State Prison Inmate Health Database (ref 3).
[21] Minnesota State Prison Inmate Health Database (ref 3).
[22] Minnesota State Prison Inmate Health Database (ref 3).

understood as representing a consistent level of faulty reporting on the part of inmates. That does not exhaust this category, though.

These high rates of "unexplained" illness also correspond to an increase in the rate of psychiatric diagnoses at the prison.[23] According to the inmate medical case files, approximately 3% of all inmates were diagnosed with a mental illness in 1870, as seen in Figure 8.[24] This was also the first year for this category to appear preprinted on the inmate medical case form. This rate remains steady through 1885. Between 1885 and 1895, the rate of insanity diagnosis by the physician increases by 10%; in 1885, 5.8% of all inmates were diagnosed with a form of mental illness and by 1895, this diagnosis increased to 15.1% of all inmates.[25] This increase in diagnosis corresponds with a change in medical providers and practice within the prison. In 1888, Dr. Willis H. Pratt stepped down from his duties and Dr. Burton J. Merrill was hired. Dr. Merrill brought with him a new generation of medical thought—the idea of criminality as a disease of the mind. The physician wrote, in 1914, "If the person's attitude and conduct toward laws, society, and his fellows are at variance with established social usages, there is something wrong with the inner man, the mind."[26] This perception of criminality changed the definition of mental illness in the correctional setting and therefore altered the rate of diagnosis.

---

[23] The impact of mental health considerations on prison medical practice is discussed in the following two chapters.
[24] Inmate Medical Case Files, 1854–1919, Box 154.4.1a-154.4.1d, Minnesota History Center, Saint Paul, MN.
[25] Minnesota State Prison Inmate Health Database (ref 3).
[26] Inmate File, 1870–1910. Box 125.F.7.7B-125.F.6.9B, Minnesota Historical Society, Saint Paul, MN

Prior to 1905, all inmates diagnosed with insanity were sent to state mental asylums, located in St. Peter, Minnesota or Rochester, Minnesota.[27] This practice changed in 1905, when the files indicate that many insane inmates were treated within the prison, while only some were sent to the state asylums. This shift corresponded to the hiring of a part-time psychologist in 1905 to help treat inmates. In 1905, 36% inmates at Minnesota State Prison were diagnosed with a form of mental illness.[28] Of these, the newly hired psychologist treated 30% on-site and a mere 6% were sent to state asylums.[29] The prison physician treated the remaining inmates, as he had been doing before the arrival of the psychologist. Here, Minnesota is again consistent with national trends. Social scientists in general, and psychologists in particular gained an increased presence in American prisons in the early twentieth century.[30] According to a 1929 volume on medicine in prisons published by the American Prison Society, by 1925, 73% of American prisons had at least one psychologist or psychiatrist as a salaried medical officer.[31] The newly-appointed prison psychologist at Minnesota State Prison at Stillwater was responsibly for classifying inmates upon entry and arranging an individualized treatment plan if necessary. This process, as well as the growing presence of mental illness diagnosis the prison, is discussed in depth in the chapter that follows.

---

[27] Inmate Medical Case Files, 1900–1972, Box 26.C.5.1B-126.C.3.5B, Minnesota Historical Society, Saint Paul, MN
[28] Inmate Medical Case Files, 1900–1972, Box 26.C.5.1B-126.C.3.5B, Minnesota Historical Society, Saint Paul, MN
[29] Minnesota State Prison Inmate Health Database (ref 3).
[30] See the more thorough discussion in Chapter 4.
[31] Frank Rector, *Health and Medical Service in American Prisons and Reformatories* (New York: The National Society for Penal Information, 1929).

The discrepancy between the large numbers of patients and the small medical staff defined the limits and possibilities of how prison physicians prevented, diagnosed, and treated both physical and behavioral disease. Doctors combined physical treatment of ailments with the social world of the state prison to create effective physical cures for diseased bodies and minds.[32] No single ailment better exemplifies the responses required of the physician to execute these treatment plans as the population grew than the case of tuberculosis.

Tuberculosis is a contagious disease that thrives in the crowded conditions that were common in nineteenth-century prisons. Tuberculosis affected every social class, geographic location, and race, and was responsible for one out of every five deaths the early twentieth century America.[33] The infection rate of tuberculosis in the Minnesota State Prison was high, even compared with its prevalence in the general population. The prison physicians commonly held that combination of heritage and immoral behavior caused the disease. Having a high infection rate from tuberculosis reflected poorly on the administration and the prison's ability to reform and maintain the health of its inmates, and so controlling the disease was a priority for prison physicians for administrative as well as medical reasons.

In the absence of a known cure or reliable treatment, tuberculosis patients and their physicians experimented with a variety of interventions. The most common treatments in nineteenth-century America focused on climate, exercise, ventilation and

---

[32] Non-biological aspects of medical practice in the prison are discussed in more detail in Chapter 4.
[33] Shelia Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in America* (New York: Basic Books, 1994): 2.

airflow, and diet. California, Colorado, and New York became recognizable treatment destinations for patients. At the end of the nineteenth century/beginning of the twentieth century the open-air treatment method utilized new architectural forms, such as sleeping porches, and focused on improving ventilation. [34] Open-air treatment and exposure to sunlight were popular methods used in private and public sanitaria and hospitals.[35]

Another popular cure was rest. The rest cure dictated that patients remain still. Physicians believed that patients' organs and tissues could not handle the stress of the environment.[36] In extreme rest cases, patients moved their bodies in small increments only. Patients' mobility often began by bending fingers. More extreme treatments included hydropathy, experimental surgeries, and radical living conditions, like "sunshine boxes."[37] The lower classes of American society could not afford access to such treatments. Tubercular inmates in prisons had similar accessibility issues and were forced to accept whatever treatment the institution offered.

In 1912 there were approximately 1200 cases of tuberculosis in the America prison system of about 106,000 inmates.[38] Tuberculosis was present at Minnesota State Prison from the institution's creation in 1851 through the mid-twentieth century. The first tuberculosis death recorded at Minnesota State Prison was a white male, Inmate No. 19, who died in 1851 at the age of forty. Inmate No. 19 was the first of over 1000 patients

---

[34] Thomas M. Daniel, *Captain of Death: The Story of Tuberculosis* (Rochester, NY: University of Rochester Press, 1997).
[35] René J. Dubos, *The White Plague: Tuberculosis, Man, and Society* (New Brunswick, NJ: Rutgers University Press, 1987).
[36] Shelia Rothman, *Living in the Shadow of Death* (ref 33).
[37] Myers, J. Arthur *Invited and Conquered: A Historical Sketch of Tuberculosis in Minnesota* (St. Paul: Webb, 1949).
[38] Rector, *Health and Medical Service* (ref. 31), 153.

diagnosed with tuberculosis in the prison between 1850 and 1930, and one of hundreds of deaths from the disease.[39]

Tuberculosis was endemic in institutions. The physicians at Minnesota State Prison often resorted to extreme measures in their attempts to stem the disease, including an entire restructuring of the hospital wing and eventually the hospital building. Dr. Merrill described the importance of isolation of tubercular patients at Minnesota State Prison in 1894:

> The contagious character of tuberculosis is now admitted. The contagion is exhaled from the lungs and thrown out in the sputum. Hence it follows that as a sound preventative and hygienic measure, the isolation of consumptives and immediate destruction of the contagious germs, is of the first importance. The earlier is done better. This is especially true in an institution of this character and in this cold, where in wintertime it is necessary to limit free ventilation and be closely housed. In this I think we are now in advance of any similar institution in the country.[40]

In addition to isolation, inmate patients were treated with exercise, diet, sunlight, ventilation, hydropathy, and rest. The disease that created fear across the country threatened the prison population in Minnesota and compelled the prison physicians to experiment with treatment regimens to control the infection rate within the prison.

On March 15, 1885, 25 inmates visited the prison physician at morning sick call complaining of "weak lungs."[41] Dr. Pratt diagnosed these patients with tuberculosis and

---

[39] Minnesota State Prison Inmate Health Database (ref 3).

[40] *Eighth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending July 31, 1894* (Saint Paul, MN: Pioneer Press Company, 1894). The prison also purchased a microscope and basic laboratory equipment for the on-site hospital in 1894. This allowed for the physician to diagnose tubercular patients on-site, instead of sending laboratory material to the University of Minnesota for analysis.

[41] In both the warden's notebook and the physician's records: Warden's Record Book 1851–1875, Minnesota Historical Society, Saint Paul, MN; Notebook of Dr. Burton Jay Merrill, Washington County Historical Society, Stillwater, MN.

sentenced them to an exercise treatment regimen. Nineteenth-century physicians believed that exercise treatment expanded the lungs and size of the chest, thus improving respiratory health. Regular exercise was often coupled with "outdoor exposure," according the prison physician. In 1886, an exercise facility was built on the grounds of Minnesota State Prison to facilitate these exercise treatments.[42] The gymnasium had enough space and equipment for six inmates and included machines and chest weights for exercise. The exercises included resistance strength training and stamina building. The room had windows along the exterior facing wall, which offered two additional treatments: sunlight and fresh air.

The prison physician believed the exercise regime was improving the health of the infect inmates. In 1887 he wrote in his personal notebook: "A study of the inmates treated through the year shows many most pleasing results. In those infected the disease was retarded in progress, and for a time, decided physical improvement was noticeable in the increase of weight and lung expansion. Without exception the convicts expressed themselves as much benefited." The death rate does not suggest such improvement, however. Between 1880 and 1885, tuberculosis-related deaths accounted for 35% of all deaths in the prison, a significant increase.[43] After 1886, when the prison physician implemented the exercise routine, tuberculosis-related deaths actually increased to 47% of total deaths in the prison.[44]

---

[42] Physicians Notes in Hospital and Clinic Records, Minnesota Historical Society, Saint Paul, MN.
[43] Hospital and Clinic Records, Minnesota Historical Society, Saint Paul, MN; Inmate Records, 1871–1911, Minnesota Historical Society, Saint Paul, MN.
[44] Hospital and Clinic Records, Minnesota Historical Society, Saint Paul, MN; Inmate Records, 1871–1911, Minnesota Historical Society, Saint Paul, MN.

This increase in death rate may have been directly due to the vigorous exercise regime. Exercise causes a rise in body temperature that can induce a fever in already infected patients. Dr. Pratt also recorded in a number of patient files that "hemorrhaging" occurred during exercise time. Additionally, Dr. Pratt noted many deaths occurred within hours of partaking in the exercise treatment at the prison. This occurs in one out of four tuberculosis deaths during these years. It appears that the exercise treatment may have further agitated the already fragile conditions of the tubercular patients at Minnesota State Prison.[45]

The death rate from tuberculosis decreased after 1912, the year the Minnesota State Prison at Stillwater moved to a new location with more space for inmates and a separate hospital for treating patients, which included a quarantine ward for tubercular patients. Overcrowding in the old prison had created perfect conditions for tuberculosis to spread among inmates—multiple inmates in cells encouraged transmission from cellmate to cellmate, and higher rates of interpersonal contact in the prison yard, workshops, and other common spaces hastened its progress through the population. The new prison, perched atop a hill overlooking the St. Croix River, was built with an eye to managing the disease's spread. The higher elevation and facing windows promoted better ventilation in cellblocks and workspaces at the new prison site. While the new hospital's isolation ward was not limited to only tubercular patients, they remained the majority on the ward.[46]

---

[45] Hospital and Clinic Records, Minnesota Historical Society, Saint Paul, MN; Inmate Records, 1871–1911, Minnesota Historical Society, Saint Paul, MN.
[46] *Seventeenth Biennial Report of the Minnesota State Prison (1911-1912)* (Stillwater, MN: The Mirror, 1912).

In 1912, examination and treatment for tubercular inmates also began upon entry to the prison. All prisoners were examined, as had occurred since the creation of the prison, upon entry. Those exhibiting any pulmonary weakness were assigned to outdoor work assignments along with a special low protein diet. They were weighed weekly and given weekly physical examinations. Beginning in 1911, these patients were subject to regular sputum tests. If diagnosed with tuberculosis, an inmate was sent to the infectious disease ward of the new prison hospital. On the ward, the inmates lived in isolation and were exempt from work.[47]

The treatment plan for tubercular patients at Minnesota State Prison at the new site in 1912 mimicked the open-air treatment plan present at Minnesota Sanatorium for Consumptives, more commonly called Ah-gwah-ching, which opened in Walker, Minnesota in December 1907.[48] During the planning of the new Minnesota State Prison, Dr. Merrill visited Ah-gwah-ching to examine the institutional policy and procedure for treating tuberculosis patients. While he does not cite this visit as an influence on his recommendations for the prison hospital, Merrill's suggestions to the Board of Control reflect the conditions at Ah-gwah-ching.[49] These suggestions included more ventilation in cellblocks, windows for more sunlight in the cellblocks and hospital, more outdoor space for inmates, and an "airy, open location" for the new prison.[50] The prison physician

---

[47] *Seventeenth Biennial Report of the Minnesota State Prison* (ref. 46).

[48] Aw-Gaw-Gung means "out-of-doors" in Ojibwe, the language of the Ojibwe Indians, the largest native American tribe in Minnesota. See: Minnesota Sanatorium for Consumptives, Oral History Transcripts, Minnesota Historical Society, Saint Paul, MN, Box 106.I.11.2F

[49] Superintendent's Files, Minnesota Sanatorium for Consumptives, Minnesota Historical Society, Saint Paul, MN, Box 106.I.6.5B.

[50] *Fifteenth Biennial Report of the Minnesota State Prison (1907–1908).* Stillwater, MN: The Mirror Office, 1909.

believed that tubercular inmates should spend the majority of their day outdoors performing nominal exercise. In addition to light outdoor exercise, these inmates were assigned a diet of three quarts of milk and six raw eggs, which was similar to the diet for patients at Ah-gwah-ching. The doctors at Ah-gwah-ching argued that tubercular patients should consume easily digestible foods to increase nutrient intake in hope of strengthening the patient's body. The high calorie intake also added weight to the emaciated bodies of tubercular patients.[51]

The number of tuberculosis cases at the Minnesota State Prison declined significantly beginning in 1920. By then, tuberculosis related infection accounted for only 15% of all respiratory and infectious diseases in the prison. This decline continued over the following decades. But even as the disease itself waned, tuberculosis treatment had a lasting effect on the prison structure. The prison physician secured isolation rooms and eventually a tubercular ward to isolate tuberculosis patients from healthy patients. This simple change in the physical structure of treatment prevented the transmission of the disease to healthy inmates at the prison. The physician also created exercise areas for tuberculosis patients that remained even after his experimental treatment plan evolved. These yards were later used for convalescing patients to exercise and get fresh air.

The presence of a significant tuberculosis population in the prison compelled the physician to create not only a place of treatment, but also a treatment regime. When traditional open-air treatments were not achievable or effective in the prison, the

---

[51] Tuberculosis Program Files, 1927–1943, Minnesota Sanatorium for Consumptives. Minnesota History Center, Saint Paul, MN, Box 106.I.11.8F. Although these records are from the mid-twentieth century, it is clear that the treatment programs, outside the tests administered, remained similar through the mid-twentieth century.

physician trialed alternative treatment programs. Although his unorthodox treatment regimen proved to be ineffective, and perhaps detrimental to inmate health, it nonetheless shows the physician's dedication to tailoring medicine for the growing inmate population.

Conclusions

The prison population of Minnesota was booming in the opening decades of the twentieth century. This growth placed significant pressure on prison administration to grow the physical structure of the prison, as well straining its rehabilitative mission as both the institution and the physician increasingly felt the tension between caring for the individual and caring for the population. The physician responded to these circumstances by examining the growing population and its characteristics, and adjusting both his medical care of inmates and space in which he practiced.

This is highlighted by the care of tubercular inmates at Minnesota State Prison in the late nineteenth and early twentieth centuries. In caring for the growing number of inmates at the prison, the physician understood that the infectious characteristics of tubercular inmates threatened the health of non-infected inmates. To care for infected inmates, and prevent infection of health inmates, the physician established isolation wards for inmates with tuberculosis. Within the ward, the physician experimented with forms of treatment that fit the prison's physical limitation, making the prison a laboratory of medical practice. In the physicians' responsibilities not only to the health of individuals, but also to an entire population, we see the how striking the balance between individual and population health influenced the nature of his role; the growing prison

population, its medical characteristics, and the space in which it was contained defined prison medicine as a distinct category of practice.

Chapter 4:
Policing the Mind: Phrenology, Psychology, and the Era of the Curable Criminal, ca. 1890-1920

Introduction

Phrenological and psychological interpretations of deviance assumed a central role in American prisons at the turn of the twentieth century. Once medical doctors began to define and treat criminal behavior as an illness in the 1890s, prison medical staff turned to medical methods and diagnostics to cure the supposed disease of criminality, a behavioral disorder that was thought to predispose individuals toward criminal activity. As new therapeutic goals joined preexisting punitive and moral reform goals, prison physicians took on a greater role in the mission of the prison, implementing methods of classification and individual treatment programs that encompassed far more than rest, diet, exercise, and medication. The primary goal of the physician and the prison was to create individual treatment plans for inmates perceived to be suffering from an array of physical and mental disorders. Inmates were classified not by criminal offense, but by degree of criminality. Inmates afflicted with criminality could be released from prison when sufficiently "cured" in the eyes of the physician, in line with the indeterminate sentencing that was introduced by social reformers in the same era. With the assumption of this responsibility, the prison physician gained more power in the closing decades of the nineteenth century. He not only decided how to treat inmates and ascribe labor assignments, but also recommended to the parole board who got to leave prison and when.

This elevation of the prison physician's role came from viewing criminality as a disease that could be cured with appropriate individual treatment. In essence, the construction of criminal behavior as a disease defined all inmates as patients. As prison became more focused on providing inmates with systematic medical care as part of their therapeutic goals, prison medical staff drew from a diverse range of medical theories and types of providers, including phrenology—an early attempt to take a naturalistic approach to the investigation of mental phenomena that used skull contours as a supposed indicator of character traits—which reached its peak in the late nineteenth-century. Phrenologists reasoned that criminality was a disease of the mind. Only a trained phrenologist, they argued, could measure and identify these abnormalities.

As an application of the theory of criminality as a disease, which gained traction in America around the same time phrenology was reaching the peak of its popular appeal, phrenologists who saw a place for their work in American prisons recommended individualized treatment plans to "cure" inmates of criminality. These plans often included a balance between work, counseling, and self-reflection. Despite phrenologists' abiding interest in criminality and detailed plans to address it within the prison structure, few nineteenth-century prisons implemented phrenological models. It was not until the newly professionalizing field of psychology turned its attention to criminal reform that systematic approaches to mental evaluation and classification became common in the prison system. Nonetheless, the precedent that nineteenth-century phrenologists established for the psychological classification of prisoners shaped the implementation of subsequent criminal reformation programs within America's prisons at the end of the

nineteenth century. Evaluating how phrenologists plied their trade within the prison can therefore illuminate the process by which psychological classification schemes became meaningful penological tools.

Using the Minnesota State Prison at Stillwater as a primary case study, this chapter examines the prison as a laboratory of medical practice, where both phrenologists and psychologists put the precepts of their maturing fields into action. The presence of both phrenologists and psychologists shows that the prison was open to exploring new medical frameworks. Psychologists did not have professional authority in the medical field. They looked to the prison as a site in which to develop and exert the professional authority they craved. Establishing authority in the prison, they believed, would aid their attempts to grow it further in the broader society. That prison authorities, including physicians, accepted psychologists and their ideas of criminal reform into the prison, indicating that the prison itself was in the process of transforming from a punitive and reformative to a medically/behaviorally therapeutic institution.

The rise of mental health classification and treatment schemes in the prison further expanded the role of the prison physician and the scope of prison medicine. By identifying criminality as a disease, and treating it in the prison, the physician enacted a new system for classifying inmates while simultaneously making mental health an integral portion of his responsibilities. While the classification system was meant to help the prison manage the care of these inmates, it was also a way in which the physician exerted influence over the prison's organizational structure. The physician's responsibility for identifying criminality, developing treatments to modify behavior, and

creating a new classification system shows the expanding role of the prison physician around the turn of the twentieth century.

Phrenologists were unsuccessful in their efforts to have their theories and methods of treating criminality as a mental illness adopted in prisons in the late nineteenth century; however, physicians and psychologists were successful in their efforts to expand their authority in the early twentieth century through the medicalization of criminality. Phrenology was available as a model for physicians and psychologists as they looked to expand and establish their authority in the prison. Both phrenologists and psychologists responded to the realization that the mind was available to be classified as a medical domain, but only one group was successful at doing so—the psychologists.[1]

Phrenological Theories of Crime and Criminality

Phrenology is the detailed study of the size and shape of the cranium as a supposed indicator of moral character, intellectual ability, and mental health.[2] It was first established by German physician Joseph Gall in 1796 and was further developed by his collaborators, Johann Spurzheim[3] and George Combe.[4] Phrenologists believed that the

---

[1] Physicians diagnosed and treated inmates with the disease of criminality until the psychologists entered the prison in the early years of the twentieth century. When psychologists joined the medical staff, classifying and treating inmates with mental illness became the domain of the psychologist(s).

[2] Stephen Tomlinson, *Head Masters: Phrenology, Secular Education, and Nineteenth-Century Social Thought* (Tuscaloosa: University of Alabama Press, 2005).

[3] Spurzheim, like Gall, was German born and studied medicine in Vienna. It was during his time in Vienna that Spurzheim became associated with Gall. It was Spurzheim, not Gall, who carried their phrenological theories to Great Britain and the United States. Gall was the originator of the system of phrenology. Spurzheim was its propagandist. See: Stanley Finger, *Minds Behind the Brain: A History of the Pioneers and their Discoveries* (Oxford: Oxford University Press, 2000).

[4] The German-born Gall, was a prominent Viennese physician. His early research focused on anatomy, specifically cranial anatomy. In 1807, Gall relocated to Paris from Vienna. During his

landscape of the cranium could explain every form of human behavior. They undertook empirical studies of the heads of individuals, including criminals, to establish and test their hypotheses regarding the correlation of faculties to behavior.

By the mid-nineteenth-century, phrenology was a widespread and popular science in America and was being used to study behavioral abnormality, including the disease of criminality. Spurzheim brought phrenology to the attention of American physicians and social scientists during his North American lecture tour in 1832. In the audience of one of Spurzheim's lectures was George Caldwell,[5] an American physician.[6] Caldwell undertook the study of phrenology and incorporated it into the courses he taught at the medical school at Transylvania University, Lexington, KY. Caldwell's first phrenological publication, *Elements of Phrenology*, was released in 1824.[7]

In *Elements of Phrenology*, Caldwell reviewed the fundamental phrenological assumptions put forth by Gall and Spurzheim: the brain was the organ of the mind, an organ that was compound and complex. He described the three regions of the brain—the

---

time in Paris, Gall worked with the French physician and proponent of psychological theory, Philippe Pinel. On Gall's contribution, see: Finger, *Minds Behind the Brain* (ref. 3). George Combe was a British phrenologist, credited for the spread of phrenology to the United States. During his lifetime, he published an impressive body of literature concerning phrenology and medicine. On Combe's contribution, see: Paul A. Erickson, *Phrenology and Physical Anthropology: The George Combe Connection* (Halifax, Nova Scotia, Canada: Saint Mary's University Press, 1979).

[5] Charles Caldwell studied medicine at the University of Pennsylvania. Upon graduating, Caldwell organized the medical department and became a Professor of Medicine and Clinical Practice at Transylvania University, Lexington, KY. Caldwell attended Spurzheim's lectures in Paris during a trip to Europe in 1821 to purchase books for the medical library at Transylvania University. See: Johnson Allen and Dumas Malone. *Dictionary of American Biography*, Volume 3 (New York: Charles Scribner's Sons, 1977), 46; Charles Caldwell, *The Autobiography of Charles Caldwell* (Philadelphia: Lipincott, Grambo and Co., 1855).

[6] Caldwell, *Autobiography* (ref. 5).

[7] Charles Caldwell, Francis Jeffrey, John R. W. Dunbar, *Elements of Phrenology*, 2nd edition (Lexington, KY: A.G. Meriwether, 1827). The first edition was published in 1824.

active propensities, the moral sentiments, and the intellectual faculties—and characterized the specific organ that produced cranial protuberances.[8] These protuberances, according to Caldwell's account, could be measured to determine the degrees of various character traits. Caldwell reasoned that cranial protuberances no only describe current character, but also the likelihood of future behavior. Thus, with this method, phrenologists might be able to predict the occurrence of criminal behavior.

The majority of Caldwell's publications are dedicated to the description and analysis of phrenological definitions of criminal behavior.[9] To phrenologists, the disease of criminality was defined and diagnosed by the presence of over-developed faculties. Caldwell examined the skulls of inmates and identified three propensities—Philoprogenitiveness, Destructiveness, and Covetiveness[10]—that were present and overdeveloped in almost all criminal subjects. George Combe, who defined Philoprogenitiveness as "the propensity of parental love", also employed these capacities. Combe noted that it is almost always larger in women than it is in men. Destructiveness, if large, "fills the mind with wants…which require work as a means to satisfy them." If small, Destructiveness describes an "easy going soul, content with everything."[11]

---

[8] The active propensities, moral sentiments, and intellectual spirit loosely alight with behavior, morality, and intellect. See: John Davies, *Phrenology: Fad and Science; a 19th-century American Crusade* (Hamden, CT: Archon Books, 1971).
[9] In addition to his *Elements of Phrenology*, also see: Caldwell, *Autobiography* (ref. 5); Charles Caldwell, "New Views of Penitentiary Discipline and Moral Education through Reformation of Criminals," *Phrenological Journal* 7 (1882): 384–410 and 493–517; Charles Caldwell, "Thoughts on the Most Effective Condition of the Brain as the Organ of the Mind, and on the Modes of Attaining It," *American Phrenological Journal and Miscellany* 1, (1839): 393–430; Charles Caldwell, "Thoughts on the True Connexion of Phrenology and Religion," *American Phrenological Journal and Miscellany* 1 (1839): 324–330.
[10] George Combe. *A System of Phrenology* (Boston: Marsh, Capen, and Lyon, 1838).
[11] Caldwell, et al., *Elements of Phrenology* (ref. 7), 68.

Covetiveness, also labeled as acquisitiveness, is the greed to increase one's possessions. These three propensities were the fundamental faculties used to diagnose criminality. For example, Caldwell notes in *Elements of Phrenology* that twenty-seven of twenty-nine females who had been found guilty of infanticide displayed an enlarged organ of Philoprogenitiveness. Destructiveness, Caldwell wrote, "when not properly balanced and regulated by superior faculties, led to murder."[12] Covetiveness, Caldwell remarked, "unless restrained and properly directed by the higher faculties …[led] to great selfishness and theft."[13] This described a necessity for individual acquisition, which included obtaining things without regard to value or to the consequences of the taking.[14] The propensities that dictated criminal behavior, according to Caldwell's description, were more difficult to control than other propensities.[15]

In this hierarchy of propensities, sentiments, and intellectual faculties, the higher controlled the lower; that is, the sentiments controlled the propensities, while the intellectual faculties directed and governed the whole.[16] As a result, in the phrenological system, it was difficult to predict whether the intellectual faculties of an individual would operate for good or for evil.[17] For example, other faculties would not control an individual with an overly developed organ of Covetiveness; Covetiveness occupied the peak of the hierarchy. The result would be an individual with dishonest behavior and a

[12] Caldwell, et al., *Elements of Phrenology* (ref. 7), 71.
[13] Caldwell, et al., *Elements of Phrenology* (ref. 7), 73.
[14] Caldwell, "New Views of Penitentiary Discipline" (ref. 9), 493–494.
[15] Charles Caldwell, "Phrenology Vindicated Against the Charges of Fatalism," *American Phrenological Journal and Miscellany* 2 (1839): 98–110.
[16] Caldwell, "Phrenology Vindicated" (ref. 15), 103.
[17] Caldwell, "Connexion of Phrenology and Religion" (ref. 9).

proclivity toward theft.[18] If, at the same time, the organs of piety and self-esteem were also stimulated, "the will throws its support on the side of virtue and subdues completely the propensity to vice."[19] If the organ of Destructiveness were overdeveloped, this would lead to murderous tendencies.[20] But, if the intellectual organs of organs of conscientiousness, benevolence, or piety were most strongly developed, an individual would be more inclined toward virtue.[21]

Caldwell believed that individuals derived propensities from the environment; criminal behavior was not inherited. A strong propensity to commit a crime, Caldwell held, did not imply a necessity to commit it. Caldwell insisted that man was a free agent, and the higher faculties could govern the lower. If the higher faculties were not called into action, the fault was not nature, but the individual who misused his/her gifts.[22] Caldwell reasoned that man was not born with organs or faculties that were "evil." Additionally, unlike Gall and Spurzheim in the previous decades, Caldwell argued that there were no organs of theft or murder. Instead, larcenous and murderous tendencies resulted from the neglect and abuse of the organs of Destructiveness, and Covetiveness.[23]

The American followers of phrenological applications to questions of crime were not limited to academicians and physicians. Amariah Brigham was the superintendent of the New York State Lunatic Asylum at Utica, and was the founder of the *American*

---

[18] Caldwell, "New Views of Penitentiary Discipline" (ref. 9), 494.
[19] Caldwell, "New Views of Penitentiary Discipline" (ref. 9), 388.
[20] Caldwell, "New Views of Penitentiary Discipline" (ref. 9), 389.
[21] Caldwell, "New Views of Penitentiary Discipline" (ref. 9), 391.
[22] Caldwell, et al., *Elements of Phrenology* (ref. 7), 124.
[23] Caldwell, et al., *Elements of Phrenology* (ref. 7), 128.

Journal of Insanity.[24] In the second volume of the journal, Brigham wrote of criminals "being unfortunate victims of a physical organization which was defective and in which the influence of the higher faculties was small while that of the propensities was great."[25] He estimated that nine-tenths of the criminals at the New York Lunatic asylum were "governed by animal propensities."[26] Brigham's assistant at the New York Lunatic Asylum at Utica, H. A. Buttolph,[27] continued Brigham's research in criminal phrenology in an 1849 article in the *American Journal of Insanity*. Buttolph acknowledged that the disease of criminality could affect the organs of feelings, "exciting, depressing, or perverting them so that the end result was some sad and unlooked-for catastrophe."[28]

Buttolph, like Brigham and Caldwell, reasoned that criminality was not a product of nature, but rather the environment and society. It would seem, then, that if a criminal were removed from his or her toxic environment, individual faculties would be transformed. Prisons, in the phrenological paradigm, were therefore a suitable response for the treatment of criminals—inmates would be separated from malicious environments that contributed to the development of criminal propensities and, at the same time, not taint otherwise reasonable social atmospheres. Phrenology justified the existing institutional system.

---

[24] Amariah Brigham, "'Journal of Prison Discipline,' and Lunatic Asylums," *American Journal of Insanity* 2 (1845): 175–183. See also: Finger, *Minds Behind the Brain* (ref. 2).
[25] Brigham, "Prison Discipline" (ref. 24), 180.
[26] Brigham, "Prison Discipline" (ref. 24), 179.
[27] A later article published by Buttolph in 1854 in the *American Journal of Insanity* suggests that he was later the superintendent of the New Jersey Lunatic Asylum at Trenton. See: H. A. Buttolph, "On the Physiology of the Brain and its Relation in Health and Disease to the Faculties of the Mind*," American Journal of Insanity* 42 (1886): 277–316.
[28] H. A. Buttolph, "Relation Between Phrenology and Insanity," *American Journal of Insanity* 6 (1849): 131–132.

Phrenology held that inmates should be held and treated at the prison until the inmate was cured. The concept of behavioral treatment was compatible with the concept of altering moral character and behavior of inmates, as advocated by the Pennsylvania System. Although most prisons during the nineteenth-century had transitioned to, or were established as, Auburn-style prisons, they maintained the moral reform aspect of the Pennsylvania System (see Chapter 2). From the phrenological standpoint, encouragement of the higher faculties could lead to genuine moral rehabilitation. The consilience between the prevailing understanding of criminality and the precepts of phrenology made prisons a natural place for phrenologists to practice.

Phrenologists held that inmates should be released when they were successfully cured, which offered a reward for the "good behavior" of inmates following their individualized treatment plans. The prison physician nominated an inmate for release when he felt the inmate was cured. This medical approach to captivity was consistent with indeterminate sentencing laws started in the nineteenth-century by American social reformers and described in the writings of Dwight and Wines. Dwight and Wines challenged the punishment feedback in the Auburn system by suggesting a system of positive incentives instead. When an inmate performed well in the prison, he could be rewarded with a reduced sentence.

Phrenology in the American Prison

Given the compatibility between American criminal phrenology and the existing institutional structures and penological theories, the prison became a natural site for

phrenological research. Phrenologists were fascinated by criminality and often reported on the contours of prisoners' heads. Phrenological studies of the correlation between skull size and behavior offered suggestions for how to treat criminals to ultimately cure their criminality. Within the prison, phrenologists aspired to rehabilitate inmates to the point where they could interact as valuable members of society. The phrenologists believed that with a properly modified environment and the correct treatment, inmates could be reformed. On the strength of these goals, indeterminate sentencing of prisoners won phrenological support.[29] If the prison was to be therapeutic and rehabilitative, individualized treatment of inmates was necessary. The duration of sentences should not be determined by the nature of crimes, but by the diagnosis and degree of criminality. Phrenologists argued that the professional healers in the prison should determine when a patient, or inmate, was cured and could be released. Prisons, they believed, should be designed to rehabilitate, and medical professionals—with the assistance, of course, of phrenological insight—should be empowered to determine when that rehabilitation was successful.

Phrenologist George Combe[30] maintained that every prisoner should be phrenologically classified upon incarceration.[31] A few American prisons openly

---

[29] Nicole Rafter*, The Origins of Criminology: A Reader* (New York and London: Routledge, 2009).
[30] George Combe, *Elements of Phrenology,* Third Edition (Edinburgh: John Anderson, 1828); *Lectures of Phrenology; Including its Application to the Present and Prospective Condition of the United States: with Notes, and Introductory Essay, and an Historical Sketch by Andrew Boardman* (New York: Published by Samuel Colman, 1839); *Remarks on the Principles of Criminal Legislation, and the Practice of Prison Discipline* (London: Simpkin, Marshall and Company, 1854); and *A System of Phrenology* (Boston: Marsh, Capen, and Lyon, 1838).
[31] This proposition was later embodied in Edward Livingston's penal code. See: Edward Livingston, *A System of Penal Law for the United States of America: Consisting of A Code of*

associated themselves with the new doctrine. For example, under the wardenship of John Edmonds, Sing Sing prison briefly adopted phrenology to shape inmate treatment. The primary proponent of this change was Eliza W. Farnham, who introduced phrenology to the prison in 1844 while working as the matron of the women's prison at Sing Sing.[32] While most of Farnham's work was with women offenders, her program of assessment and treatment reached part of the men's prison as well. Farnham, in line with Caldwell's view, believed that criminality was the product of circumstance and the environment. Treatment of felons, she believed, involved the removal of elements from the offender's environment that stimulated "animal propensities."[33] This process of rehabilitation could never be achieved with harsh punishments. Although widespread in the women's prison at Sing Sing, her efforts were short-lived. The warden supported Farnham's efforts until his resignation in 1845, after which the Board of Control continued support for only one more year.[34] Despite its short tenure, this example demonstrates how phrenological principles worked in concert with the penal philosophies that governed prison structure at the time.

Crimes and Punishments; A Code of Procedure in Criminal Cases; A Code of Prison Discipline; and A Book of Definitions (Washington, DC: Gales & Seaton, 1828).

[32] See: Janet Floyd, "Dislocations of the Self: Eliza Farnham at Sing Sing Prison," *Journal of American Studies,* 2 (2006): 311–325.

[33] John Dunn Davies, *Phrenology: Fad and Science* (New Haven, CT: Yale University Press, 1955).

[34] See: John Dunn Davies, *Phrenology: Fad and Science* (New Haven, CT: Yale University Press, 1955); Nancy McKinney, "Eliza W. Farnham (November 17, 1815 – December 15, 1864)" in *Early American Nature Writers* (Westport, CT: Greenwood Press, 2007).

This idea of modification and treatment of criminality is also evident in the case of the phrenologist Professor George Morris at Minnesota State Prison.[35] Morris and his wife were the founders of the St. Paul Phrenological Society in St. Paul, Minnesota.[36] The society met quarterly to discuss recent phrenological studies by members and often hosted phrenologists from societies across the country to talk about current trends in the science of phrenology. In 1891, Morris spoke to the society about his work in Minnesota State Prison at Stillwater.[37] Inspired by the work of leading phrenologists, and the success some of them had enjoyed making inroads into prisons, Morris wrote to Warden Wolfer of Minnesota State Prison about a study he would like to conduct with inmates. His methods were simple—he planned to measure faculties of inmates during routine medical exams or during incoming/exiting medical exams. Morris assured the warden that his work would not disrupt the routine of inmates or prison officials. He even noted that he would only need one chair and "a quiet corner" to do his work.

[35] Material to George Morris is always addressed as "Professor" George Morris. He also signs correspondence letters as "Professor George Morris." However, no record of medical or graduate education can be found. He did attend numerous classes at phrenology schools in Washington State and Oregon. It is likely that his title of "professor" is self-proclaimed.

[36] George Morris was not a resident of Minnesota at the time. Correspondence records indicate that he was residing in Oregon at the time of founding. Upon marrying his wife, an Iowa native, he moved to the Midwest and continued his phrenological pursuits. George Morris Correspondence, St. Paul Phrenological Society Papers, Minnesota Historical Society, Saint Paul, MN, BM7/.S257, 1880.

[37] George Morris' phrenological studies in Minnesota are relatively late, past the heyday of phrenology's popularity and professional acceptance in the United States and abroad. Meeting Minutes of the St. Paul Phrenological Society, August 1893, St. Paul Phrenological Society Papers, Minnesota Historical Society, Saint Paul, MN, BM7/.S257.

Morris won the warden's permission to conduct his study and spent over a year studying inmates in Minnesota State Prison.[38] His records were meticulous. Morris recorded measurements and observations of each participating inmate in separate files. In these files, Morris recorded his phrenological measurements for specific faculties, such as Destructiveness, Conscientiousness, and Acquisitiveness, circled ratings that were considered "abnormal" by phrenological standards, described the "overall look and appearance of the presenting inmate's cranial structure," hair color, race, eye color, and neck shape.[39] In addition to physical records, Morris included notes about inmate behavior that he observed in the prison yard and at religious services.

Morris lived like one of his inmate subjects during his yearlong study at the prison. He worked quietly with inmates in a corner of a hospital ward corridor and ate his lunch in the prison yard, according to the warden, like "a lame duck waiting to be retrieved."[40] Morris even attended religious services at the prison. His time there, though, was strictly observational, not therapeutic. Morris writes, in a letter to the Phrenological Society, "I continue my studies at the prison, not just with my calipers, but throughout the prison community. I attend religious service with inmates Sundays. There, I record the inmate numbers of those in attendance. As of yet, no relation is to be seen between

---

[38] The warden, though, seemed uninterested in his work. His correspondence with Morris was professional, although he did not inquire about the details of Morris' work, nor did he ask why he was interested in studying prisoners.
[39] George Morris, Correspondence to the St. Paul Phrenological Society, Papers of the St. Paul Society. BM7/.S257, 1890.
[40] Warden Wolfer, Correspondence and Notes in Warden's notebook, 1890, Washington County Historical Society, Stillwater, MN.

religious men and biological faculty."[41] His comments imply that he was looking not just to measure physical faculties, but also to correlate these with observed behavior.

At the conclusion of his study at the prison, Morris outlined a series of recommendations for prison reform. In his paper, which he intended for publication, he theorized a hierarchical classification of criminals nearly identical to that of Combe. Morris paraphrased Combe's descriptions:

> The first level of criminals are those who have appetites or propensities powerful enough to overbalance the restraining force of their moral and intellectual faculties. These men are perhaps the easiest to identify, as abnormality can be seen with the eye alone. The second class of criminal are those whose animalism is as strong as the first class, but whose religious and intellectual integrity are much more commendable. The third class are few in the prison. For these men it is physically possible to rob, or steal, or torture, or murder, but it is nearly morally impossible.[42]

In addition to describing levels of criminality, Morris set down a rehabilitation routine for each class. He indicated how his routine could be included in the existing medical structure at the prison. In addition to physical exams upon entry, Morris recommended that the physician classify the animalism and degree of criminality, assessed through an interview, of each inmate.[43] The inmates should then, according to Morris, be housed in the prison according to their classification and should receive individualized treatment according to their faculties. To Morris, the criminal mind required a challenge just as much than the criminal body required detention. Morris recommended that each inmate be "treated to a series of discussions with a qualified

---

[41] George Morris Correspondence. St. Paul Phrenological Society. Washington County Historical Society, Stillwater, MN.
[42] George Morris, St. Paul Phrenological Society Papers, Washington County Historical Society, Stillwater, MN.
[43] It seems that Morris is referring to the animal nature of an individual, or the degree of unrestrained response present during the interview.

counselor."[44] Each inmate would participate in a different number of meetings, as the frequency and content of sessions were determined by inmate need. "There was no timetable to keep" with these meetings, Morris wrote; an inmate "should be charged with an indefinite sentence. His release should only be charged when he is successfully cured of his criminality."[45]

Morris' recommendations were progressive for his time. His findings were based on precise observation and measurement, something that many phrenological studies of the late nineteenth-century lacked. Morris sent his observations and recommendations to the Minnesota State Prison warden, but no change in policy or procedure was immediately evident. This is no surprise, as the warden's comments describing Morris as a "lame duck" implied the warden had a rather low opinion of the phrenologist. Morris' suggestions were detailed, but perhaps too radical for the social and penological context. In the early part of the twentieth century, however, the Minnesota State Prison would adopt classification and counseling procedures similar to those recommended by Morris, but only after these were suggested and implemented by more traditional "men of science"—the prison physician and psychologist—and only after psychology had become established as a mainstream scientific discipline.[46]

---

[44] Morris did not specify what training was required to be a "qualified counselor." It might be assumed that it would be a phrenologically or medically trained individual.

[45] George Morris to the St. Paul Phrenological Society, 1890 Papers of the St. Paul Society, Minnesota Historical Society, Saint Pail, MN, BM7/.S257.

[46] See: Helmut E. Adler, *Aspects of the History of Psychology in America 1892-1992* (New York: New York Academy of Sciences, 1994); Thomas Haskell, *The Emergence of Professional Social Science* (Urbana: University of Illinois Press, 1977); Thomas Haskell, *The Emergence of Professional Social Science* (Urbana: University of Illinois Press, 1977).

Morris' work did, however, expose prisons officials to medical accounts of criminality. While they did not adopt his suggestions, his work may have eased the transition to importing psychology into to medical practice of the prison in the early years of the twentieth century. The scientific legitimacy of psychology, combined with widespread acclimatization to medical accounts of criminality provided by the work of Morris and other phrenologists in the prison, fostered the presence of psychological classification and treatment practices and staff in the prison during the next decade.

The Rise of Psychology in the American Prison

Phrenologists implemented careful, systematic methods to study the skulls of inmates of prisons across the United States. They used findings from these studies to reject the idea of criminality as an inevitable, untreatable natural state and instead advocated for a social and environmental understanding of criminality. In addition to defining criminality as a disease of the mind, these phrenologists solicited detailed treatment programs for inmates to be deployed in prisons. These treatment regimens called for indeterminate sentencing, individualized treatment programs, and regular counseling.

Despite an impressive body of literature concerning the cause and treatment of criminality, phrenology made little direct contribution to actual practice in prisons of the same era. Physicians, some of whom once had practiced the art of phrenology, came to reject it as a sham science, based on false assumptions. Established medical professionals denied that any connection obtained between the exterior of the skull and the brain.

Nevertheless, phrenology played a significant role in sensitizing prison administrators to the naturalistic categorizations of criminality that psychologists would later promote. Phrenologists developed a theory of the cause of criminality, one that recognized the need for individualized treatment. Without the support of professional medical groups; however, phrenologists could not practice in a clinical capacity or implement their prescriptions. Psychology, looking to gain professional status, would adopt similar ideas about the causes and treatment of criminality, and psychologists' identity as clinicians and counselors gave them professional authority to practice what phrenologists had only been able to preach.

The role of the professional medical staff of the prison, beginning with the physician and expanding to psychology staff, preserved the central elements of the theories phrenologists had pioneered. First, the prison medical staff began to examine individual inmate family, social, and medical histories. Surveys designed to establish such history were added to the standard intake evaluation.[47] The physician would begin with a physical examination and Bertillon measurement.[48] The physician would also conduct a medical history interview where inmates would be asked questions about their drinking and smoking habits, family medical history, personal medical history, and other details.

---

[47] In the early year of the twentieth century, it was often the prison physician that physically and psychologically examined inmate upon entry to the prison. By the 1910s, many prisons in the United States had hired a psychologist, either part-time or full-time, to assist in the psychological diagnosis. See: Frank L. Rector, *Health and Medical Service in American Prisons and Reformatories* (New York: The National Society of Penal Information, Inc., 1929).
[48] Alphonse Bertillon, "The Bertillon System of Identification," *The Forum* 11 (1891): 330–341.

In Minnesota, for example, the inmate medical registry form changed in 1905, the same year a part-time psychologist was hired to assess inmates upon arrival. The expanded medical form included prompts for age, height, hair color, eye color, birthplace, medical history, mother's birthplace, father's birthplace, tobacco use, temperance, notes on inmate character, overall appearance, notes on behavior, and family medical history.[49] Each inmate file was completed in full, and the physician began to sign each form with his initials. These registry forms were used to develop individualized treatment plans for incoming prisoners.

Second, the prison medical staff developed a new classification system to "diagnose" and "treat" inmates, one that was similar to the system developed by phrenologists at the end of the nineteenth-century. After the physical evaluation and medical interview by the prison physician, the prison physician or psychologist determined a level of criminality of inmates through a psychological interview. The prison physician could provide an initial diagnosis of mental illness, including the disease of criminality during inmate intake exams, and did so regularly before the hiring of a full-time psychologist. When the psychologist was hired in the prison, diagnosis of criminality, and all mental illness, became the professional responsibility of this specialist and his staff. When diagnosis became the responsibility of the psychologist, rates of severe criminality diagnoses and other mental illness went up in the prison, as they

[49] Physical condition record, 1875–1913. Minnesota State Prison Collection. Minnesota Historical Society, Saint Paul, MN.

brought with them a new level range of mental illness diagnoses.[50] This increase in mental illness diagnosis was discussed in the previous chapter.

This psychologist's classification would determine an inmate's placement in the prison and would also be used to determine an individualized treatment plan. These diagnoses determined the amount of times per week an inmate would meet with the prison physician or psychologist, an inmate's placement within the cellblocks, and the inmate's work assignment. Though receiving individual treatment plans, incoming inmates were grouped into levels of criminality that determined their physical placement within the prison.[51] Inmates were assigned to cellblocks that were specified for "incurable," "severe," "moderate," and "minimal" criminality.[52] The segregation of these classes of inmates served to prevent inmates of higher levels of criminality from negatively influencing those of lower levels. This segregation of inmates also had a practical motive: it made managing discipline and distributing guards within the prison easier. The criminality diagnosis was dynamic and prison psychologist or physician could categorize an inmate in higher or lower categories based on his/her behavior in the prison and counseling assessment.

These treatment plans incorporated not only medical intervention, but also "treatment" through work, exercise, and interaction within the prison. For example,

---

[50] The diagnosis of criminality would again change when a criminal asylum was established on the grounds of St. Peter State Hospital in the early-twentieth centry. The physician and psychology staff transferred more patients to the asylum. At the same time, the mental rehabilitation of inmates shifted from the prison to the asylum for the criminal insane. This greatly affected the level of criminality diagnosis in the prison, and will be discussed in depth in Chapter 5.

[51] Rector, *Health and Medical Service* (ref. 47), 125.

[52] Rector, *Health and Medical Service* (ref. 47), 239–244.

inmates at Minnesota State Prison were assigned work placements based on their psychological interview now, not just their physical health. Work placements were defined by social interaction, vocation, and location. Inmates who exhibited exceptional reform, that is significant behavioral modification and superior reports by the prison psychologist, were given positions that offered a considerable amount of interaction with inmates and prison officials. Some inmates were even placed in office positions within the prison administration.[53]

Psychology and the Treatment of Criminality in American Prisons

By the end of the nineteenth-century, phrenology lost what few scraps of professional authority it had managed to assemble both in America and abroad. The medical professions that once accommodated the original phrenologists now ignored their studies. The work of the early phrenologists, though, laid the theoretical framework for defining criminality as a deviant but mutable behavioral state. Psychologists adopted this as a clinical method for the treatment of inmates in the early-twentieth century. As the newly appointed physician at Minnesota State Prison, Burton J. Merrill, wrote in 1914: "If the person's attitude toward laws, society, and his fellows are at variance with established social usages, there is something wrong with the inner man, the mind."[54] Merrill understood his responsibilities to include treating inmates with infectious diseases, injuries, and the curable criminals with mental aberrations, making the medicine he practiced in the prison more sharply distinguished from practice outside the prison

[53] *Fifteenth Biennial Report of the Minnesota State Prison (1907–1908)* (Stillwater, MN: The Mirror Office, 1909).
[54] Dr. Burton Jay Merrill, Notebook. Washington County Historical Society, Stillwater, MN.

than it already was by virtue of its institutional context. The close integration with emerging psychological principles promoted an integrated perspective on physical, mental, and social health that was particular to the correctional context. Prison physicians saw inmates as patients and the prison therefore more as a hospital where people suffering from criminality could be "cured." This expanded view of disease within the prison meant that Merrill alone could not care for all of the "sick," nor did he possess all of the requisite skills to do so. The addition of professional psychological staff would be necessary if he was to properly care for the immense body of "diseased" prisoners.

At first, diagnosis and treatment of criminality fell to Merrill, the only medically trained staff member of the Minnesota State Prison, who treated 90% of inmates between 1890 and 1907 for physical and mental ailments.[55] The addition of a part-time psychologist in 1905, whose major responsibility was diagnosing, counseling, and curing criminality at the prison, relieved Merrill of some of this burden.[56] As the number of inmates in need of treatment increased, the psychologist was appointed as a full-time staff member in 1926.[57] An additional psychologist and a psychiatrist would join him in the next few years. There was no other medical staff added at the prison during the first half of the twentieth century, making it more notable that the prison devoted more staff and funding to mental health rather than general health.

---

[55] Physical condition record, 1875–1913, Minnesota State Prison Collection, Minnesota Historical Society, Saint Paul, MN.

[56] *Fourteenth Biennial Report of the Minnesota State Prison (1905–1906)* (Stillwater, MN: The Mirror Office, 1907).

[57] *Twenty-sixth Biennial Report of the Minnesota State Prison (1929–1930)* (Stillwater, MN: Prison Printing Dept., 1930).

These upward trends in criminality diagnoses and staff hiring at the Minnesota State Prison are consistent with national trends in the employment of social scientists in American prisons. According to Rector's 1929 volume on medicine in prisons published by the National Society of Penal Information, by 1925, 73% of American prisons had at least one psychologist as a salaried medical officer.[58] By 1926, 19% of prisons employed psychiatrists, and 82% had psychologists, with the former group holding medical degrees and the latter completing coursework and apprenticeships in a developing social science field.[59]

In the case of Minnesota, the prison board assembled in 1905 to review the files of three finalists for the position of managing mental health in the prison. Of the three, one was a physician who identified as a psychiatrist and the other two were professionally trained psychologists, with training and professional coursework in psychology. The board of the prison felt that the psychology candidates had more extensive and suitable training for the position.[60] Higher salaries for psychiatrists might have also influenced this assessment, as the accompanying medical degree demanded a higher financial compensation. Two-thirds of the applicants for the position were psychologists, reflecting the field's interest in expanding its professional boundaries and claims of expertise. Psychologists aspired to gain an institutional foothold to help define their professional status in relation to the field of medicine.

---

[58] Rector, *Health and Medical Service* (ref. 47), 88.
[59] Rector, *Health and Medical Service* (ref. 47). 89.
[60] Warden's Record Notebook, 1890–1912, Washington County Historical Society, Stillwater, MN; Warden Wolfer to the Board of Control, in Assorted Warden Correspondence, 1900–1920. Washington County Historical Society, Stillwater, MN.

Once professional psychologists became integral to the prison medical system, inmates diagnosed with curable criminality were subject to treatment within the prison walls. In a manner similar to the counseling program advocated by George Morris after his phrenological assessment of inmates in 1891, affected inmates met with psychologists at least one time per week, but some as many as five times per week, depending on the specific diagnosis.[61] In these counseling meetings, psychologists monitored behavioral change and character. Prison psychologists did not view counseling sessions as treatment. Instead, they used these observations and interviews to plan a treatment program within the strictures of the prison structure. Prisoners would be given work assignments that were meant to help cure him or her of criminal behavior. More severe cases would be assigned to positions in the boiler and mechanical rooms, while convalescing inmates would work in less physically but more socially demanding positions, such as in the kitchen and the prison library.

Psychologists often adjusted counseling and work to changes in an inmate's behavior. One prisoner, referred to hereafter as Mr. E, but his case illustrates the dynamic nature of diagnosis and treatment. The case of Mr. E is discussed in detail in chapter two as a case of malingering. Here, the case of Mr. E is examined for the psychological and counseling that he received. Mr. E was incarcerated with an indefinite sentence in 1900, and quickly developed a pattern of malingering and escape attempts.[62] Part of the treatment plan Dr. Merrill devised for Mr. E employed the services of the prison

---

[61] Statistical Record, Minnesota State Prison Collection, Folder 4, Minnesota Historical Society, Saint Paul, MN.
[62] Inmate medical case files, 1900–1972, Book 1. Minnesota State Prison Collection, Minnesota Historical Society, Saint Paul, MN.

psychologist. After being recaptured following his first escape in April of 1905, Mr. E met with the prison psychologist three times per week, an increase from the initial counseling plan at sentencing that had required him to meet with the psychologist once a week. The medical reports of this new treatment plan indicate that Mr. E was "following orders and regimen of the [prison] system," a quality that would soon earn him a new job in the twine factory in the prison and fewer weekly meetings with the psychologist.[63] His job, which was neither in isolation nor full social responsibility, indicated that he was "reforming," according to the psychologists.

Following an apparent suicide attempt in the fall of 1906, Mr. E's meetings with the psychologist became daily affairs. The psychologist wrote, in 1906: "[Mr. E] made suitable progress toward treatment until this day. His actions are spontaneous and his character questioned. If his action toward himself and others is not improved with his current treatment, he shall be transferred to St. Peter [the state asylum for the criminally insane]."[64] Mr. E's actions led the psychologists to shift his diagnosis from "criminal, but able to be reformed" to "criminally insane," according to his file, a diagnosis supported by his later actions in the prison (see Chapter 2).[65] Mr. E was admitted to the

---

[63] At the time, Minnesota State Prison at Stillwater was the largest producer of twine in the country. This title remained until the early 1940s. The profits from the sale of twine supplemented a significant part of the prison budgets. See: *Twelfth Biennial Report of the Minnesota State Prison (1901–1902)* (Stillwater, MN: The Prison Mirror Print, 1903); *Thirteenth Biennial Report of the Minnesota State Prison (1903–1904)* (Stillwater, MN: The Mirror Print, 1905); *Fourteenth Biennial Report of the Minnesota State Prison (1905–1906)* (ref. 56); *Fifteenth Biennial Report of the Minnesota State Prison (1907–1908)* (ref. 53); *Sixteenth Biennial Report of the Minnesota State Prison (1909–1910)* (Stillwater, MN: The Mirror Office, 1910); *Seventeenth Biennial Report of the Minnesota State Prison (1911–1912)* (Stillwater, MN: The Mirror, 1912).
[64] Dr. Burton Jay Merrill. Inmate medical case files, 1900–1972, Book 1. Minnesota State Prison Collection. Minnesota Historical Society Minnesota Historical Society, Saint Paul, MN.
[65] Dr. Burton Jay Merrill. Inmate medical case files, 1900–1972, Book 1. Minnesota State Prison Collection. Minnesota Historical Society Minnesota Historical Society, Saint Paul, MN.

prison hospital in 1907 after nights of howling and complaining of intense pain after sustaining a minor work related injury in the twine factory. The hospital steward administered a small dose of morphine to Mr. E and left the room to attend to other patients. After the hospital steward had left, Mr. E grabbed the bottle of morphine and drank its contents. Mr. E was transferred to the state asylum days later.

The case of Mr. E illustrates the problematic nature of diagnosing and curing a patient suffering from the behavioral disease of criminality within an institution whose structure and policies reflected its primary punitive function. While Mr. E's indeterminate sentence may have contributed to a view of the prison as therapeutic, his manipulation of the prison medical system makes it clear that he (and probably many other inmates) did not share that view. Psychological diagnosis and treatment of inmates differ from traditional medicine because of the degree to which prisoners could be expected to resist their diagnosis and subsequent attempts at a cure.

The medico-psychological framework of criminal disease made diagnostic classification a critical concern for the early-twentieth-century penal system. It became a practical device for segregating inmates and creating categories within the prison system, and a powerful tool for controlling inmate behavior and social control in the prison. Prison boards supported this medical endeavor because it gave them more control and new justifications for that control, while simultaneously promoting the image of the prison as a therapeutic institution. For example, release from the prison became the responsibility of the prison physician and parole board. Only when an inmate was

certified as “cured” would a physician nominate an inmate for release, after which a board of prison administrators determined their fate.

Members of the prison medical staff who advocated indefinite sentencing held that an inmate must be sufficiently “cured” for release. Release from a prison, like release from a hospital, carried the physician’s implicit certification that the patient posed no threat to the health of the community. When the psychologist felt that the inmate had reached a desirable level of reform, he would send a recommendation to the prison physician, who would recommend to the warden that the prisoner be evaluated by the parole board. It was ultimately the parole board, not the prison medical staff, which made the decision as to whether an inmate would be released as “cured” or “reformed.” The parole board allegedly acted on the recommendations of the medical staff of the prison. In practice, this recommendation process did not occur frequently. Few inmates were nominated to the board as “cured.”

Conclusion

While the work of phrenologists was preliminary and motivated few changes within the prison, their work laid the theoretical framework of defining the curable criminal. The prison medical staff adopted this theoretical framework and offered a clinical methodology for treating and reforming inmates with criminality in the prison. By the start of the twentieth century, psychologists were regular medical staff members of prisons across the United States, not least because the field was interested in expanding its professional boundaries and claims of expertise. Incoming prisoners at

Minnesota State Prison in Stillwater, Minnesota, beginning in the 1900s were classified using criteria based on their crimes, sex, and health conditions in order to distribute them within the physical structure of the prison. With the growth of social science in the early twentieth century, this taxonomy shifted and prisoners were classified by degree of criminal behavior, similar to classifications in the hospitals and asylums, based on their degree of psychological deviancy. This shift further expanded the scope of prison medicine, and helped reorient the penal philosophy of Minnesota State Prison at Stillwater towards a rehabilitative ideal.

Psychology was a maturing field in the early twentieth century, and the prison was a place where psychologists could gain professional authority that they hoped to expand. The prison was willing to expand and implement this new medical framework, acting as a laboratory of medical practice. Hospitals of the period could not do this, as they were more conservative intuitions with set procedures. The relationship of psychology and prison practice was a mutually beneficial one, as psychologists gained experience and professional authority and the prison expanded their scope of practice.

The expansion of medical practice in the prison to include mental health was another element that distinguished prison medicine from private practice. Curing the criminal became the responsibility of the physician in the prison context. Mental healthcare was also an aspect of prison practice where the physician could exert power in the prison. The physician was responsible for classifying inmates according to their mental health profile, which defined an inmate's physical place in the prison, as well as

an inmate's job placement. Classification of inmates in the prison was an important psychological reform.

Chapter 5:
The Decline of the Rehabilitative Ideal: The Rise of the Criminal Asylum, 1875–1920

Introduction

"There is one needed reform that I desire to call your attention to," state prison physician Burton J. Merrill implored the Minnesota legislature in 1898:

> This is the proper disposal of the individual that is insane at the time he commits crime, and that of the convict who becomes insane subsequent to his incarceration in prison. The so-called criminal insane or insane criminal. In my opinion there is no place more unfitted for the proper care of these persons than our prison as at present operated. The superintendents of our state asylums for the insane hold a similar opinion as to the care of this class in their hospitals. Hence arises the need for the legislature to make provisions as are necessary for its special needs in caring for and treating this class of unfortunates.[1]

Despite the versatility prison physicians were forced to develop, some situations nonetheless strained their capacities. This was most common with the prisoners who put the greatest pressure on the tension between the prison physician's role as healer and disciplinarian. Such prisoners came to be classified as criminally insane in the early twentieth century. The impacts of this classification can be seen both in the physician's role in prison and in institutional developments. This chapter explores these changes and argues the criminal asylum was formed as a direct response to these tensions.

David Rothman, as discussed in the Introduction, examined the characteristics of state-run institutions to argue that these institutions manifested social control over their charges. Rothman's picture works well when examining individuals and their trajectories

---

[1] *Tenth Biennial Report of the Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending in July 31, 1989* (Stillwater: The Prison Mirror, 1898), 45.

through institutional life. However, the definitive tensions in the prison physician's role did not emerge in the same way from individual-level interactions. Rather, they came from the pressures of enacting an institution-level mission while coping with a growing population of prisoners. Rothman emphasizes power dynamics, which, of course, did play an important role in prison life. But power is only one aspect of control. Another aspect, one that was more central from the medical perspective within the prison during the early-twentieth century, was managing the rapidly expanding population. This variety of social control was less about exerting power over inmates than it was about effectively controlling population health.

The growth of the criminally insane population in the United States during the late nineteenth and early twentieth century was an institutional problem that required an institutional solution. Representatives of both prisons and asylums perceived an absolute and proportional rise in the numbers of the criminally insane.[2] From the perspective of these institutions, the formation of criminal asylums served as a pressure valve for the strained resources of both prisons and asylums, neither of which was designed or equipped to cope with the people who were both criminals and insane within their populations. Before the advent of the criminal asylum, when prison physicians

---

[2] For example, see the annual reports of the Minnesota State Prison and nursing records of the St. Peter State Asylum: *Eleventh Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending July 31, 1900* (Minneapolis, MN: Price Brothers Co., 1900); *Twelfth Biennial Report of the Minnesota State Prison (1901–1902)* (Stillwater, MN: The Prison Mirror Print, 1903); *Thirteenth Biennial Report of the Minnesota State Prison (1903–1904)* (Stillwater, MN: The Mirror Print, 1905); *Fourteenth Biennial Report of the Minnesota State Prison (1905–1906)* (Stillwater, MN: The Mirror Office, 1907); *Fifteenth Biennial Report of the Minnesota State Prison (1907-1908)* (Stillwater, MN: The Mirror Office, 1909); Daily Reports of Head Nurse, 1893-1913, Records of St. Peter State Hospital for the Insane, Minnesota Historical Society, Saint Paul, MN.

encountered prisoners whose mental health needs they could not address and who were also dangerous, physicians faced the option of accommodating them uncomfortably within the prison or exhausting some of their capital with the local asylum in hopes it would accept the person. The criminal asylum offered a third option: an institution specifically designed to cope with a population that strained the missions of other institutions. This also resolved the prison physician's professional dissonance, as he now had the option to refer inmates to an institution that included therapy as its primary mission, and in which discipline was secondary but still prominent.

The limited medical staff at Minnesota State Prison was not capable of providing sufficient care to the criminal insane in the ending decades of the nineteenth-century as the prison population grew. At the same time, Minnesota asylums lacked the security to successfully detain criminals. Because the criminal insane could not be easily accommodated in either institution, the criminal asylum emerged as a timely addition to Minnesota's institutional landscape, not only providing a suitable place of care and discipline for the criminal insane, but also relieving the prison of a growing, and uncontrollable, population, and partially resolving the physician's dual responsibility in treating these inmate patients.

Literature Review and Context: The Asylum in America

The history of the asylum in the United States falls into three eras: moral treatment and the birth of the asylum in the early-nineteenth-century, the moral hygiene movement in the early-twentieth century, and the mental health movement of the late-

twentieth century.[3] This chapter will focus on the development of the asylum system in Minnesota, and its care of the criminal insane, during the nineteenth and early-twentieth centuries, and will therefore address the first two periods of asylum history. As the care of the insane shifted from the prison to the asylum, the prison physician's role also shifted, as psychological rehabilitation became the responsibility of specially trained psychology and psychiatry staff both in the prison and in the newly established institution for the criminally insane.

Widespread social reform in the early nineteenth century inspired medical reform for the care of the insane. Reform during this period was not based in religion, as it had been for the Quakers, but rather in the growing medical understanding of health and behavior. The work of Dorothea Dix, a social activist for the care of the insane in the mid-nineteenth century, for example, was essential in securing funds from the United States government to develop an asylum system in post-Civil War America.[4] Dix also lobbied for educational initiatives for deaf and blind individuals at a state level, since the education system was not equipped to educate the disabled population of America. With compulsory education in place throughout the country, Dix encouraged states to follow through on their responsibility to provide the adequate resources for disabled students. Mid-nineteenth century physicians of this period argued that behavior was influenced by

---

[3] Sal Cohen. "The Mental Hygiene Movement, the Development of Personality and the School: The Medicalization of American Education" *History of Education Quarterly* 23 (1983):123-148; Norman Dain. *Clifford W. Beers: Advocate for the Insane* (Pittsburgh: Pittsburgh University Press, 1980); Theresa Richardson. *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany: State University of New York Press, 1989).

[4] Leila Zenderland, *Measuring Minds: Henry Herbert Goddard and the Origins of American Intelligence Testing* (Cambridge: Cambridge University Press, 1988).

environment, advancing the idea that changing environment could be therapeutic. This ideal inspired the creation of asylums across the United States during the late nineteenth-century.

An example appears in Nancy Tomes's *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840-1883*, a history of the Pennsylvania Hospital for the Insane, a private American asylum.[5] Tomes tells the story of Thomas Kirkbride, a distinguished American asylum superintendent of the mid-nineteenth-century.[6] At the time, the Pennsylvania Hospital for the Insane was considered the pinnacle of moral treatment in America, the equivalent of Hospice de la Salpêtrière, the professional home of Philippe Pinel, a French physician whose work centered on moral treatment of the asylum patients, in France.[7] Kirkbride was one of the leading figures among American asylum superintendents and the author of an influential book on asylum architecture in the period, *On the Construction, Organization and General Arrangements of Hospitals for the Insane*.[8]

A Generous Confidence traces the history of psychiatric confinement of the mad at the Pennsylvania Hospital from the construction of the first wholly separate insane asylum in West Philadelphia in 1841 to the mid-1880s.[9] The hospital was one of only a

[5] Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840–1883* (Cambridge: Cambridge University Press, 1984).
[6] The St. Peter State Hospital for the Insane is a Kirkbride building. Correspondence concerning the design of the newly established asylum between Kirkbride and the medical superintendent are plentiful in the late nineteenth-century. This will be discussed later in the chapter.
[7] Tomes, *A Generous Confidence* (ref. 5), 62.
[8] Tomes, *A Generous Confidence* (ref. 5), 6.
[9] This long period coincides with the superintendence of Thomas Story Kirkbride, one of the "original thirteen" alienists who founded the American Psychiatric Association, and one of the dominant figures in the formative years of the American asylum system.

small number of “corporate asylums” operated exclusively for the middle and upper classes, and in no way like the overcrowded and underfunded public hospitals, as Tomes’ describes as “monasteries of the mad.”[10] Kirkbride, too, was an atypical figure. His plan for patient rehabilitation in the late nineteenth-century American asylum was based on moral treatment. Patients were quartered in individual rooms to promote privacy for patients. The cells were built into long hospital-like wings and had windows for light and fresh air, a model reproduced in the structure of the new 1912 Minnesota State Prison, which promoted cross ventilation and sunlight to promote inmate health. The structure itself of the Kirkbride asylum was supposed to promote health.[11] These buildings were set on large plots of land, which allowed for patient exercise, also a form of rehabilitative therapy.

Kirkbride’s architectural ideals for treatment of inmates at the Pennsylvania Hospital endured through the 1880s, when his contemporaries began to question his approach to asylum architecture, patient treatment, and moral rehabilitation of the insane. Kirkbride’s critics did not share his optimism regarding treatment of the insane, and instead favored a custodial approach more in line with standard medical practice, which could be offered at a fraction of the cost of Kirkbride’s moral reform approach.

Kirkbride’s approach spread across the United States in the mid-nineteenth century, and many hospitals were built according to the Kirkbride plan in the 1850s and 1860s.[12] The growing moral treatment movement accompanied Kirkbride’s therapeutic

---

[10] Tomes, *A Generous Confidence* (ref. 5), 22.
[11] Tomes, *A Generous Confidence* (ref. 5), 14.
[12] Carla Yanni, *The Architecture of Madness; Insane Asylums in the United States (Minneapolis: University of Minnesota Press*, 2007), 18–19.

architectural style. This form of treatment emerged out of social movements, led by Dorothea Dix, to provide humane and non-restraint based treatment of the mentally ill.[13]

Similar studies by Ellen Dwyer of the Utica State and Willard Asylums in New York State shared Tomes's topic and perspective.[14] Dwyer described the New York asylum system through the daily lives of doctors, staff, and confined patients.[15] Using the records of two different types of asylums—the New York State Lunatic Asylum at Utica intended for short-term curable patients and the Willard Asylum for the chronic insane—Dwyer reconstructed the inner life of the asylum and its inhabitants. Her accounts of patient behavior, the intellectual and cultural biases of the staff, and the socio-demographic characteristics of patients are testimony to the asylum's multifaceted purposes. Patients, doctors, nurses on the wards, politicians in Albany, and the families who brought their loved ones to the asylum often agreed about the necessity for the asylum even as they held their individual and often incompatible notions about the wide variety of medical and social functions it served. "No one metaphor evoking either cell or sanctuary prevailed," Dwyer found.[16]

While belief in environmental impacts on health and behavior endured through the twentieth century, the place of the asylum as a therapeutic environment changed dramatically. The asylums of the previous century, once created for care and

---

[13] Gollaher, David. *Voice for the Mad: The Life of Dorothea Dix* (New York: Free Press, 1995).
[14] Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987).
[15] Dwyer, *Homes for the Mad* (ref. 14), 215.
[16] Dwyer, *Homes for the Mad* (ref. 14), 1.

rehabilitation, had become custodial institutions.[17] This was in large part due to the influence of state legislatures and funding limitations, rather than changes in medical theory on treatment of the insane. State legislatures defined asylums in terms of community protection, much like they did the prison, instead of in terms of reform, rehabilitation, and care of its patients. Institutional practice, in particular for state institutions, was more commonly driven by financial concerns and other factors of expedience than it was by ideology.

External pressures continued to constrain the role of the asylum into the twentieth century. Gerald Grob and David Rothman discuss the custodial aspects of asylums in twentieth-century America. Grob argues that twentieth-century American asylums were well intentioned, but overwhelmed by patient populations whose growth rate far outstripped that of the staff and facilities. David Rothman expanded the view of the asylum system to include not just homes for the insane, but also prisons, juvenile reformatories, and public hospitals. Rothman, like Grob, describes an asylum system that failed to appropriately treat and care for their inmates and patients. His argument, however, draws more sinister conclusions, describing a Kafkaesque system of government-run institutions that cared more about expanding their social control than treating patients.

---

[17] See: Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991); *The Mad Among Us: A History of Care of America's Mentally Ill* (New York: Free Press, 1994); *Mental Illness and American Society* (Princeton: Princeton University Press, 1983); *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920* (Chapel Hill: University of North Carolina Press, 1966).

Rothman was one of the first historians to examine the role of the asylum in the hierarchy of state and social order in the early twentieth-century United States. Until his first publication in 1971, historians wrote predominantly about the history of specific institutions and the great doctors who ran them. Rothman studied the asylum as a necessity in establishing social order, focusing much of his study on society itself. According to Rothman, by the early nineteenth-century, the traditional and stable society of the colonial period began to disintegrate. Rothman argues that early-nineteenth-century Americans concluded that "to comprehend and control abnormal behavior promised to be the first step in establishing a new system for stabilizing the community, for binding citizens together."[18] The solutions that Americans adopted in the nineteenth-century involved the creation of the "asylum."[19] The institution's social role was to isolate the social deviant from society at large and rehabilitate; however, by the end of the nineteenth-century, most of these institutions abandoned any pretense at rehabilitation and rapidly degenerated, serving as a mere "dumping ground for social undesirables."[20] Thus, these institutions of isolation existed simply to confine society's "unwanted." Rothman claims that these institutions persisted because it was easier for society to confine undesirables in mental institutions and prisons than to seek new and different solutions to a growing social problem.

---

[18] David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (New York: Aldine de Gruyter, 2002), 59.
[19] The asylum, according to Rothman, in this context can be defined as an institution that would reform criminals, juvenile delinquents, poor and indigent groups, mentally ill persons, and all other deviants whose abnormal behavior might or did threaten society.
[20] Rothman, *The Discovery of the Asylum* (ref. 18), 286.

Rothman, in *Conscience and Convenience*, extends his thesis to the development of related responses to social deviance that arose in Progressive era America, which Rothman defines as the period between 1900 and 1950, namely the psychopathic hospital.[21] Rothman claims that Progressive social reformers were acting out of "conscience" in their efforts to remedy the institutional horrors of the overcrowded asylums.[22] The "new" Progressive attitude understood deviance in terms of individual causes, not social ills, as the Jacksonians in an earlier period had maintained. Thus correction in asylums occurred through individualized treatment and would often require acclimating the deviant to society rather than simply isolating him/her therefrom.

"Convenience" in Rothman's dichotomous title is threefold: despite their theories, the Progressives found it convenient to continue to confine deviants in asylums and prisons, convenient to place the burden of rehabilitation on the individual inmate, and convenient to rely on the recommendations of self-serving institution officials.[23] Throughout the Progressive era, convenience outweighed conscience and, as the era drew

---

[21] David J. Rothman, *Conscience and Convenience: the Asylum and its Alternatives in Progressive America* (New York: Aldine de Gruyter, 2002).

[22] Jacksonian Americans of the nineteenth century were dissatisfied with colonial procedures, and they began to question the inevitability of crime and poverty (or inherent deviance). Perfectionist beliefs that men were born innocent were abandoned and human corruption was perceived to be a derivation from external environmental factors that shaped man within his society. At the same time, rapid growth of cities, westward expansion, and social mobility undermined confidence that traditional, hierarchical communities could stabilize society. As a result, the "treatment" of criminals, paupers, orphans, and the insane shifted to punishment and retribution in isolated buildings whose architecture had been contrived to separate individuals (from society and one another within the institution) in order to promote the values of order, hierarchy, and fixity during the Jacksonian era. See: Rothman, *The Discovery of the Asylum* (ref. 18).

[23] Rothman, *The Discovery of the Asylum* (ref. 18), ix.

to a close, subdued it. The incompatibility of conscience and convenience, Rothman's main thesis, is often reinforced in the text.[24]

Most of the literature on asylums in America has argued that a philosophical shift led to changes in practice within the asylum. For example, Rothman saw changes in the care of patients, or lack thereof, as a sea change in the mission of the asylum nationwide. However, Grob has argued and the following chapter demonstrates through its examination of the criminal asylum that the mission of the asylum did not shift so dramatically. Instead, the idea of rehabilitation remained consistent in the asylum during the late-nineteenth and early-twentieth century. The shift of the asylum from a rehabilitative to convenient institution occurred because asylums had difficulty executing their rehabilitative missions. The practices of the asylum were out of step with the mission, but these differences were not driven not by a philosophical shift, but the challenge of coping and caring for a significant increase in the patient population, especially a growth of particular categories such as the criminally insane, and a staff that did not grow with it proportionately.

Rothman's and Grob's insights into the asylum provide the background and context with which to understand changes in American prisons during the Progressive Era. Rehabilitation of inmates in correctional settings declined at the start of the twentieth century as asylums became preferred sites for rehabilitative care of the insane criminal,

---

[24] For example, see: Dwyer. *Homes for the Mad* (ref. 14); Candace McGovern, "The Community, the Hospital, and the Working-Class Patient: The Multiple Uses of the Asylum in Nineteenth Century America," *Pennsylvania History* 54, no. 1 (1987): 17–33; Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services from the early 18th century to the 1990s* (London: Athlone Press, 1993); Nancy Tomes, *The Art of Asylum Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia: University of Pennsylvania Press, 1994).

those who could be "cured" of their disease of criminality. This transition was less the result of a marked shift in the prevailing penological philosophies than it was a response to population pressures, as growing inmate populations put pressure on institutional budgets and limited the capacity of staff to offer appropriate attention. Consequently, professional psychologists became rarer in prisons as the asylum began to offer them a wider array of opportunities in the 1920s.[25]

Staff at the St. Peter State Hospital for the Insane/Minnesota Security Hospital used psychiatry to develop a program for the moral reform of insane criminals in 1915. The migration of the reform ethos to an asylum context had the side effect of transforming prisons into predominantly punitive institutions, no longer driven by intention of "curing" the criminal, the responsibility for which shifted to the criminal asylum along with the relevant psychological staff. This shift impacted the way the insane were treated within the prison. Rather than viewing their mental issues in analogy to the disease of criminality—a much broader, and less severe classification that criminal insanity—which might be managed or even cured through institutional intervention, the criminal insane were understood as elements that needed to be managed with the prison's limited resources.

The transition away from a reform ideal for the prison's most troubled guests was mirrored by a similar shift in the approach towards the average inmate. The disease of criminality, as contemporarily defined, became less of a focus for the medical staff at the prison, which at this time included full-time psychologists in addition to the physician.

[25] *Eleventh Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions. For the year 1926* (Boston: Wright & Potter Printing Co., State Printers, 1927).

Some patients who were previously diagnosed with criminality were no longer labeled as such, and were instead assigned to the care of a psychologist without the diagnosis of criminality in their file. This is seen in the changes in the physician's narrative discussion in inmate medical case files. Narrative discussion in inmates of inmates' mental status or psychological profile remained the same, but diagnosis changed across time. Increasingly, the professional psychological staff treated only more complex cases of mental illness and "insane" patients were transferred to the asylum whenever possible. Changes in the medical approach both to the extreme case of the criminal insane and to more common diagnosis of criminality in this period both indicate that institutional balkanization contributed to a decline in the reform ideal.

This chapter addresses the care of the criminal insane through a case study of the relationship between the Minnesota asylum and prison system. Rapid population growth in the early twentieth-century United States increased the prison population, which forced the institution to re-examine its physical and therapeutic structure. Examining the effect of population pressures on the prison's physical manifestation and inmate care practices provides a larger context to the decline of the rehabilitative ideal. The change in reformative approaches in American prisons was not a simple matter of penal philosophies, but rather reflected influences wrought by a changing population.

Institutional Population of the Turn-of-the-Century United States

Transitions in institutional care for the insane and criminal insane in the United States were directly related to social movements, as described by the authors discussed in

the previous section. These changes were also driven by a growth in the insane and feeble minded population across the United States at turn of the twentieth century. This growth is captured in decennial censuses, and accompanying census supplements between 1840 and 1910.

The US Census Bureau enumerated the insane population of the United States in four censuses and supplements— the1840 US Decennial Census, 1880 US Decennial Census with physician supplement, 1890 US Census, and 1910 special census of the insane and feeble minded. When compared with records from individual asylums and states, early estimates of the size of insane and feeble-minded populations from the US Census greatly underestimate the insane and feebleminded population of the United States. Later special censuses by the US Census Bureau reported estimates and profiles of the feeble-minded that more closely approximated state and asylum data. This section will also describe methods for estimating and evaluating insane and feeble-minded populations in twentieth-century censuses.

The United States Bureau of the Census added a category titled "Insane and Idiots" to the decennial census in 1840. The inclusion of this category was likely due to developing awareness of mental health classification in United States medicine. According to this census, the number of "insane and idiots" in the United States was 1 to 990 of population, which would have meant a total of around 17,000 nationwide. The US Bureau of the Census summarized the population of insane and idiots among the population by region and state, which can be seen in Table 1 (p. 170-171).

The 1840 decennial census figures were highly controversial among academics, physicians, and statisticians at the time. In a letter to the *Journal of Insanity* in 1840, Dr. Edward Jarvis, physician and later president of the American Statistical Association, wrote:

> The American Statistical Society, in 1845, first analyzed the census of 1840, and then prepared a long memorial to Congress. In their petition they set for the errors, inconsistences, contradictions and falsehoods of that document, and asked Congress to disavow the whole, and cause another and correct one to be prepared and published...Besides the disagreements of several copies of the reports with each other, the document itself furnishes its own refutation. One statement contradicts another statement and shows its error.[26]

Jarvis's incredulity indicates that contemporary medical practitioners were aware that federal data was out of step with the consensus at the state and institution level.

Responses from people like Jarvis prompted the Census Bureau to reevaluate their methods, which previously collected data as part of the decennial census [?]. Attempting to correct statistical and enumeration error in the census, the Census Bureau changed their enumeration form to include the following question in the general and slave census in 1850: "Item 13. Whether deaf and dumb, blind, insane, idiotic, pauper or convict." This question endured through the 1890 census of the United States. This question was again expanded in 1880, when a physician supplement was added.[27] The US Census Bureau sent enumeration materials to all registered public institutions across the United States. Institutional representatives themselves, rather than trained enumerators, were responsible for administering the special census within the institution. Guidelines

---

[26] Quoted in Henry M. Hurd (ed.), *The Institutional Care of the Insane in the United States and Canada* (Baltimore: The Johns Hopkins Press, 1916), 414.
[27] "Special Reports, Physicians Schedule, Insane and Feeble-Minded," US Census Bureau, 1880.

indicated that the special census was supposed to be completed by full-time physicians. The actual practice is not known, but it can be speculated that institutions employed idiosyncratic enumeration methods. In addition to ascertaining the size if the patient population, the physician supplement sought a qualitative description of the institutionalized population within a specific district. The supplement was successful at generating better data about institutionalized patients, but failed to include any individuals being treated privately and/or living outside institutions. There was great variation across states, as physician participation and detail (e.g. submission of incomplete forms) varied greatly.

These statistics again drew scrutiny from medical and statistical professionals. In a special report of the US Census Bureau in 1880, the Bureau described the resulting statistics as "entirely worthless so far as the calculation of ratios of number of insane to population is concerned, since the number of insane returned in these censuses was certainly less than half the number actually present."[28] This can largely be attributed to variation in enumeration by asylums.

Definitions of "insane" were not consistent in either their content or their application. The numbers in Tables 1 and 2 reflect inconsistent application of the term, which resulted in someone with a permissive definition feeling the population estimates were underestimated and someone with a narrow definition feeling the estimates were overestimated. Insanity was a social diagnosis, not a biological one. Therefore, state and institution-level records provide a more accurate count because they better accommodate

---

[28] "Report on the Insane, etc., Eleventh Census," 1890, p. 7.

local variation in determining an "insane" diagnosis. The Census instead attempted to apply a uniform definition to a presumed homogenous landscape, and had little success. This highlights the difficulties of making nation-level population assessments in the mid- to late-nineteenth-century, both for contemporaries and for historians today.

The Bureau of the Census prepared a separate census of the insane in 1904. It is important to note that the separate census attempted to collect data only on the insane population of the United States, and abandoned efforts to examine the so-called feeble-minded population, perhaps because of the highly inconsistent definitions of insane and feeble-mindedness across the United States that varied by region and practitioner. Combining both categories in a single analysis compounded this difficulty. Additionally, substantial error would be introduced during data collection because it was difficult to gather data on feeble-mindedness in the general census, as it would usually have to be self-reported. Those who would be classified as feeble-minded often lived with families, while insane individuals tended to be concentrated in private and public asylums. In an attempt to produce better population analysis, the US Census Bureau instead decided to collect only information about insane individuals and the hospitals, both private and public, that housed them. The Bureau of the Census enumerated patients in asylums, psychopathic hospitals, and other institutions for the insane, both private and public. A second census of the insane was done in conjunction with the decennial census in 1910. Table 2 (p. 171) summarizes findings of this census, according to the Bureau of the Census, against the census questions from 1880 and 1890. But, how reliable is the supplementary census data?

An analysis of state-level records in relation to US census statistics can be seen in Table 3. Patient reports for the Minnesota State Asylum system are available in the Minnesota History Center. These records include medical history, family history, intake physical forms, diagnostic forms, and physician notes. The federal census records and state records for the same years are not identical. While the US census statistics are more accurate than in previous decades, they are not sufficient to approximate the entire population of insane. State-level records are a better indicator of insane patients, and offer more detailed and complete records. Additionally, state-level census data offers more variables with which to understand the population from a medical, demographic, and social perspective, which will be explored further in this chapter. Institutions in Minnesota, for example, were required to provide an annual report of patient population and institutional operations to the governor, which were used to determine funding, staff ratios, and to assess progress. Other offices of the state government, such as the Board of Control and State Board of Inspectors often used these annual reports to assess hygiene, health, and treatment, in order to evaluate and improve state institutions. As a result, state-level documents are typically more detailed and offer more variables with which to characterize the patient population.

As the institutional population across the United States grew, states were pressured to change their existing infrastructure to accommodate the growing population. Individual treatment regimens of the previous century were no longer viable as the patient to physician ratio grew larger. Institutions were forced to change not only their treatment plans, but also the asylum structure, at an institutional and state level, to care

for insane patients. Some states could not meet this growing demand, and asylums turned to remained mired in custodial care of patients.

When examined at an institutional level, the asylum transformation comes from the institution itself and its inability to grow with the patient population. The US census of the insane suffers from a similar issue when attempting to account for the insane population of the United States. In enumerating the population of insane, the Census Bureau attempted to operate with a single, well-bounded definition of insanity. The state-level data, however, suggests that the criteria for "insane" were idiosyncratically applied. That is, insanity was not a straightforward biological diagnosis. Diagnosis depended upon local definitions of the concept, which were influenced by physician training, education, and experience. The censuses failed to accurately enumerate the insane population of the United States because they tried to put idiosyncratic, local practice into a unitary national framework.

Table 1: *Insane population as enumerated in the 1840 decennial US census by state*.

State	General Population	# Patients Public Institution	# Patients Private Institution
Northeast			
Connecticut	309,987	138	404
Delaware	78,085	29	51
Maine	501,793	245	386
Massachusetts	737,699	644	627
New Hampshire	284,574	191	314
New Jersey	373,306	171	271
New York	2,428,921	739	1,601
Pennsylvania	1,724,033	524	1,609
Rhode Island	108,830	122	94
Vermont	291,948	148	263
Regional Total	*6,839,176*	*2,951*	*5,620*
Southeast			
Alabama	590,576	64	293
Arkansas	97,574	17	49
District of Columbia	43,712	4	17
Florida	54,477	1	21
Georgia	691,392	77	351
Kentucky	779,828	353	622
Louisiana	352,411	13	87
Maryland	469,232	175	353
Mississippi	375,651	30	168
North Carolina	753,419	181	620
South Carolina	594,398	107	406
Tennessee	829,210	131	720
Virginia	1,239,797	375	1,057
Regional Total	*6,871,677*	*1,528*	*4,764*

Table 1,continued

State	General Population	# Patients Public Institution	# Patients Private Institution
Midwest			
Illinois	476,183	50	242
Indiana	685,866	138	424
Iowa	43,112	2	9
Michigan	212,267	7	58
Missouri	383,702	60	210
Ohio	1,519,467	425	935
Wisconsin	30,945	1	10
Regional Total	*3,351,542*	*683*	*1,888*
Total	**17,062,395**	**5,162**	**12,272**

Source: Reports and Statistics from the1840 US Census, US Census Bureau

Table 2: ***Number and rate of insane individuals in US population by census year***

Year	Number	Per 100,000 of Population
1880	40942	81.06
1890	74028	118.2
1904	150151	183.6
1910	187791	204.1

Source: US Census, US Census of Insane and Feeble-Minded, 1910, Annual Report of the US Census 1904.

Table 3: *Institutional Population of Minnesota, 1910*[29]

Institutional Pop, in MN by Institution	Institution Record	US Census
Public:		
Anoka State Asylum	549	479
Fergus Falls State Hospital	1,297	1,574
Hastings State Asylum	667	478
Rochester State Hospital	1,439	1,201
St. Peter State Hospital	1,554	1,005
Total	5,506	4,744

Birthplace (by region)	%
Northeast	19
Southeast	18.9
Upper Midwest	35.5
Lower Midwest	10.5
International	16.1

Race	%
White	87.7
African American	10.1
Other	2.2

Time within Institution	%
Less than 12 months	31.1
13 months to 24 months	28.3
25 months or more	40.6

[29] The difference between the US Census and Institional records here demonstarte a signifcant issue with census ennumeration, as none of the institiotnal totals match, and they aren't skewed in the same direction. For example, the US Census shows an inflated the population of Ferfus Falls Hospital, but provides a total patient population Saint Peter State Hospital well below the institutions's record. Birthplace, Race, and Institutional Time are calculated from records of St. Peter Asylum only, provided as aggregate totals in the hospital's archive. Daily Ward Record. Records of St. Peter State Asylum. Minnesota Historical Society.

Table 4: *Average Annual Institutional Population of St. Peter State Asylum, 1875-1910*[30]

	Men	Women	Total
Average Admitted	141	302	248
Average Receiving Treatment	499	409	908
Average discharged[31]	172	88	260
Average Total Population	358	302	660

The Birth of the Asylum in Minnesota

Rapid population growth, as accurately gauged through state and institutional records, between both the insane and criminal populations motivated institutional and infrastructural change. Rehabilitation was less practical with a higher inmate population, and as Rothman notes, state institutions took on an operational principle of "convenience." The state no longer saw mental health institutions as rehabilitative, but rather an expedient place to quarantine insane patients away from the general public. With the smaller and more distinctive population of the criminally insane, though, the ideal of medical care persisted, showing that Rothman's thesis is contingent upon both scale of analysis and population issues and can be constructively complicated by focusing on state-level changes in the same period.

St. Peter State Hospital in St. Peter, Minnesota was established in 1866 to provide mental illness treatment capacity for the state. Before the establishment of St. Peter an agreement provided that Iowa would receive insane patients from Minnesota until the new facility was completed. This agreement only allowed for a small number of patients

[30] Biennal Reports of the Minnesota Hospitals for the Insane, 1866 to 1912. Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN.
[31] Average discharged includes total number of deaths each year.

to be transported to the Iowa State Hospital, and even then, only as long as Iowa's own patients did not require the full bed capacity. The first patient was sent to the Iowa hospital in April 1862.[32]

Under this arrangement 55 patients were sent to the Iowa State Hospital between April 1862 and the spring of 1866. At that time, an agreement with St. Vincent's Institute for Insane in St. Louis, Missouri was reached, where patients were received at a cost of seven dollars per week to the State of Minnesota.[33] Only after nearly 20 years of transporting insane patients out-of-state for treatment did the governor of Minnesota, William R. Marshall, agreed to construct a facility within the state, largely because of calculated cost of transporting patients over a quarter decade presented to him by the State Board of Control.[34]

In March 1866 the Minnesota legislature passed an "act for the establishment and location of a hospital for the insane in the State of Minnesota and to provide for the regulation of the same."[35] The board was authorized a budget of $15,000 to lease or purchase buildings for temporary use as a state hospital immediately. At the same time, a separate board was established to determine a permanent location for the state hospital. The "location committee" consisted of three members of the state government, W. R. Marshall, J. M. Berry, and Charles McIlrath, and the former superintendent of the Iowa Hospital, Dr. R. J. Patterson.[36]

---

[32] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 113.D.1.1B
[33] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 113.D.1.1B
[34] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 102.E.2.4F
[35] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 102.E.2.5B
[36] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 102.E.2.4F

On July 1, 1866, the committee reported to the State of Minnesota that the citizens of St. Peter had purchased a 210-acre farm for $7,000 and donated it to the state for the construction of a hospital for the insane. While the main hospital was being constructed, a temporary hospital was fashioned from a stone building already existing on the property. Planning for the hospital began immediately and Dr. Samuel E. Shants was hired in October 1866 as the medical superintendent. He came to Minnesota after leaving a position at the State Hospital for the Insane at Utica, New York. Shants worked with Philadelphia architect Samuel Sloan in design plans for the newly established State Hospital for the Insane at Saint Peter.[37] Dr. Shants and the board elected for a Kirkbride plan for the new institution. In a letter from Kirkbride to Shants in 1867, Kirkbride confided in his colleague that he "trusted Minnesota authorities would always recognize that the best hospital was always the cheapest in the end."[38]

Shants died in 1868 and Dr. Cyrus T. Bartlett of Northampton, Massachusetts was hired as the new superintendent.[39] Bartlett was a young physician. As such, he was extremely cautious about the architecture and staffing of the soon-to-be hospital for the insane at St. Peter. In 1868, he wrote:

> The architecture of the Hospital buildings appears now to be perfect for comfort and hygienic purposes as human ingenuity can devise; but all this will be in vain for the highest good unless proper persons are employed to take charge of the inmates. For the future, improvement for the most part must be looked for in the

---

[37] Records of St. Peter State Asylum. Minnesota Historical Society, Saint Paul, MN, 113.D.1.1B.
[38] Dr. Kirkbride also noted that an institution for the insane should have a maximize bed capacity of 600 patients, and the staff to patient ratio be 1:10.
[39] For brief time, documents suggest that Dr. J.E. Bowers acted as superintendent, but he appears nowhere in official board documents or government payrolls. It's likely he was acting superintendent until Dr. Bartlett was hired as a permanent replacement in 1868.

> elevation of the intelligence and character of the officers and attendants. The post of attendant is important, and the duties are peculiar and often difficult.[40]

Bartlett placed equal weight on the characteristics of the physical plant and the character of the staff who would oversee it. As the hospital prepared to admit its first wards, it was poised to enact the rehabilitative ideal that was increasingly more difficult to maintain in prisons.

By 1870, the new hospital was complete and Dr. Bartlett was responsible for the care and treatment of approximately 200 patients.[41] By 1875, the number of patients had more than doubled, to around 500. With the patient population increasing steadily—and at a faster rate than the population of the state as a whole—Dr. Bartlett and the medical staff were forced to discharge patients they deemed incurable to make room for new patients they believed could be successfully treated. It was this year that Dr. Bartlett and the board of trustees brought plans to the state government to expand the hospital.[42] Instead of approving an expansion, the state Legislature appropriated $15,000 to convert the inebriate asylum in Rochester, Minnesota to a second asylum for the insane.

---

[40] *Third Annual Report of the Board of Trustees and Officers of the Minnesota Hospital for Insane* (Saint Paul: Pioneer Book and Job Printing Company, 1870), 40.

[41] Dorothea Dix visited St. Peter in1874 according to the annual report of the hospital; however, no correspondence or personal records from St. Peter reflect this visit. Her visit was also reported in two Minnesota newspapers. No report can be found in any medical or political publication, making her visit largely supportive(?) in nature. Records of State Peter State Asylum, Minnesota Historical Society, Saint Paul, MN,113.D.1.1

[42] While the board of trustees appealed to the state government for an expansion, the hospital was under the supervision of three separate boards—the board of trustees (in charge of the facility), the State Commission (that oversaw medical practice, staff, sanitary condition, and general welfare of inmates and reported directly to the Governor of the state of Minnesota), and the State Board of Charities and Corrections (whose presence is a bit more uncertain; their reports seem to summarize those of the state commission). The presence of three governing bodies presents an interesting, but confusion/challenging, perspective to the researcher. Records of State Peter State Asylum, Minnesota Historical Society, Saint Paul, MN, 113.F.2.1.

Since their creation, the State Hospital for the Insane at St. Peter and the Minnesota State Prison had contended with the problem of the insane criminal. As indicated in the quote from Burton Merrill at the beginning of this chapter, each objected to taking responsibly for long-term retention of the criminal insane and both maintained that they lacked the facilities and expertise to provide for their care. The fact that the criminally insane did not fit with the mission of either institution, for different reasons, shows how their missions were each narrowly defined in different ways. If they were both strictly focused on confinement and punishment, this tension would not exist. Despite objections, St. Peter accepted insane criminals from the state prison on a case-by-case basis. It was not until 1906 that the fifty-bed Asylum for the Dangerous Insane was built on the grounds of St. Peter State Hospital. This was the fourth institution on the grounds of St. Peter, which already included the mental hospital, the detention hospital, and the hospital for criminal insane.[43] The Asylum for the Dangerous Insane expanded to 250 beds in 1911, when the entire campus of St. Peter State Hospital transitioned into the Minnesota Security Hospital.[44]

At the time of its establishment, the Asylum for the Dangerous Insane at St. Peter State Hospital made Minnesota one of only twenty-four states with separate facilities for the dangerous insane or criminal insane.[45] In Colorado, approximately ten beds on the

---

[43] With certain crimes, individuals were given the option to forgo a trial and conviction if he/she voluntarily entered the detention hospital, where they would be treated for their mental illness and realeased when sufficiantly rehabilitated. *Sixth Biennial Report of the State Board of Control of Minnesota for the Period Ending July 31, 1912* (Minneapolis: Syndicate Printing Co, 1912), 148.

[44] Like many other states, however, Minnesota found it necessary to keep its most violent criminal patients in the prison.

[45] Frank Rector, *Health and Medical Service in American Prisons and Reformatories* (New York: The National Society for Penal Information, 1929), 208.

first floor of the prison hospital were allocated for insane patients, who remained under the care of the prison physician.[46] In states, such as Indiana and Kansas, the hospital for the criminal insane was located within the prison walls and was under the direction of the prison medical staff. In Illinois, Michigan, and Wisconsin the hospital for the criminal insane was located near the prison, but managed by a separate medical staff and outside of the prison governing bodies.[47] Minnesota was unique in that its facility for the criminal insane was located on the grounds of the state asylum for civilians. Professionals specially trained in newly emerging psychological and psychiatric techniques treated the inmate-patients. The entire facility was managed by staff from St. Peter, but also employed guards from the state prison.[48]

The relationship between the Minnesota State Prison at Stillwater and the Minnesota Hospital for the Dangerous Insane was complex. Before the construction of the latter, the prison cared for insane inmates. On a few occasions inmates were transferred to St. Peter. These cases were few, as Dr. Merrill worried about placing "dangerous" individuals in an institution unsuited for their discipline. At the same time, however, the prison did not have the space or resources to appropriately care for the insane criminal. The physician lobbied the state for more funds to create a hospital for dangerous insane within the prison walls. His attempts were met with opposition, largely from the State Board of Control and Warden Wolfer of the prison who saw the proposal from a financial perspective rather than a rehabilitative one. Instead, Dr. Merrill appealed

---

[46] Rector, *Health and Medical Service* (ref. 45), 215.
[47] Rector, *Health and Medical Service* (ref. 45), 210.
[48] The prison guards were on duty rotation from the state prison. They were on the payroll of Minnesota State Prison, and not that of the St. Peter State Asylum.

to the Minnesota Asylum system, which was in a period of growth and expansion. An arrangement for more structured care of the dangerous insane was secured in 1906 on a limited basis.[49]

All inmate-patients at this time, regardless of initial diagnosis, came to the Minnesota Hospital for the Dangerous Insane through the prison system. They were first sentenced, processed through the prison, and eventually transferred from the prison by referral from the prison physician and/or psychologist. The number of transfers grew significantly over the next few years, as did the Minnesota Hospital for the Dangerous Insane. By 1911 it had 250 beds, nearly all of which were filled by inmate-patients. The prison now transferred more patients than ever before, as their criteria for "criminal insane" shifted from the severe cases to any case that was deemed psychological/behavioral in nature. The prison now cared for fewer patients with mental illness/behavioral disorder diagnoses, and most of its psychological staff was transferred to the Minnesota Hospital for the Dangerous Insane. The prison became a screening site: the dangerous insane were sent to the Minnesota Hospital for the Dangerous Insane, a custodial institution for those considered too far beyond the pale to be reformed. Other inmates requiring mental health treatment continued to be treated at the prison by professional psychology staff.

The only mental health medical staff remaining at the prison were psychologists that conducted evaluations upon intake and organized treatment programs for mentally ill

---

[49] Warden's notebooks, 1888–1889 and 1890–1912. Washington Country Historical Society, Stillwater, MN; *Twelfth Biennial Report of the Minnesota State Prison (1901–1902)* (Stillwater, MN: The Prison Mirror Print, 1903); *Thirteenth Biennial Report of the Minnesota State Prison (1903–1904)* (Stillwater, MN: The Mirror Print, 1905); *Fourteenth Biennial Report of the Minnesota State Prison (1905–1906)* (Stillwater, MN: The Mirror Office, 1907).

inmates being treated in the prison. Their primary responsibility was to determine where an inmate would be best rehabilitated—the prison or the criminal asylum. Slowly the prison, which once acted to rehabilitate all of its inmates, became more reliant upon the expertise of staff of the asylum system to rehabilitate those with behavioral and mental health issues. What happened was exactly what Gerald Grob described in his numerous studies of the asylum system in America—the asylum and prison were well intentioned, but could not adequately care for the growing inmate-patient population. Staff at both institutions, after the turn of the twentieth century, did not expand in proportion to general population growth as it once had. Care suffered as a result, as did the once well-intended mission of both institutions: to rehabilitate their patients so they could positively contribute to society. After a century of well-intended moral and medical care in the prison, the outcome was no longer rehabilitation. The asylum, too, failed to carry out its rehabilitative mission. Despite following very different trajectories through the late nineteenth-century, the prison and the asylum emerged from the nineteenth-century in lockstep, both having been shackled by the demands of serving an ever-expanding population.

Conclusion

The early chapters of this dissertation demonstrate how prison medicine evolved into independent species of medical practice. The criminal insane category was a continuing challenge for that practice even after it was well defined. The emergence of a new category of institution, the criminal asylum, to manage the criminal insane relieved

the prison physician of his responsibilities to try to treat this category of inmate in the prison, and demonstrated the belief that it was not his responsibility to do so. The establishment of a new criminal institution also redefined what it meant to be curable or reformable in the prison context, again in accordance with the standards of prison medicine.

The issue about where and how to care for the criminal insane adds texture to the question of how institutional missions changed in early twentieth-century America, when seen from a medical standpoint. The criminal insane were offenders who were went to prison as a punishment for a particular crime. The prison was expected to rehabilitate inmates for release, but for prisoners with serious mental illness, that task was more complex than counseling and teaching them occupational skills. Moreover, inmates whose mental illness made their behavior unpredictable and dangerous to themselves and others were not easily accommodated in the prison or even the prison hospital. Putting such inmates in an asylum setting where they could receive psychiatric treatment, however, could endanger the other patients. How did one balance this? Who should be responsible for the care of these criminally insane inmates—the prison or the asylum? Navigating these questions further complicated the already delicately balanced role of the prison physician.

The preceding chapters show how for a brief period the prison evolved as a place of rehabilitation and care, a therapeutic and not simply a punitive institution, as it is commonly understood. During the early-twentieth century, however, the rehabilitative ideal within the prison was declining. The prison physician identified that the prison,

once responsible for the moral and medical rehabilitation of its inmates, was no longer able to care for caring for mentally ill inmates. It had become an expedient institution, a convenient place for the state to sequester criminals. This is the picture advanced in Rothman's *Conscience and Convenience*, where he describes all state institutions in the early twentieth century as convenient "dumping grounds" for offenders and patients, both juvenile and adult. But changes in state institutions did not occur primarily because of the power aspects of social control that Rothman argues, but rather because of more mundane changes in population. This trend is seen in the prison system in Minnesota, but not the asylum. As the prison's rehabilitative ideal declined, the state built its first hospitals for the dangerous insane. In this sense, the care of insane criminals, those that could possibly be "cured" of their criminality if they received appropriate psychiatric treatment, was shifted from the prison to the asylum/hospital, and the rehabilitative ideal lived on.

The transition to the criminal asylum also relived pressure from the prison to care for an increasingly unwieldy inmate population. The addition of the criminal asylum to the state institution system helped to relieved the professional dissonance experienced by the prison physician, who acted as both a healer and disciplinarian in the penitentiary context. The physician was responsible for balancing these competing objectives, and he did so by crafting medicine for the prison environment. In doing so, the physician created a brand of medicine that was distinct from traditional private practice of late-nineteenth and early twentieth century American medicine.

Conclusion:
The Prison as a House of Care

The prison has been traditionally been depicted in historical literature in terms of its custodial and punitive missions. What these histories failed to acknowledge is that the therapeutic mission the prison held in the late-nineteenth and early-twentieth centuries in the Untied States was a pivotal element of its institutional character. This is evident most clearly through the practice of medicine in the prison, and can be seen clearly in the formative years of Minnesota State Prison at Stillwater. Although Minnesota State Prison adopted the physical structure of an Auburn System prison, which ostensibly would have meant it was focused on a behavioral reform program consistent with a social control narrative, the moral reform ideals of the Pennsylvania System are evident in the practice of prison officials, foremost among them the physician. Much of the institution's rehabilitative goals, in fact, fell to the medical staff, who were empowered to craft a variety of medical practice that fit the competing objectives endemic to the prison: confinement, punishment, and control on one hand, rehabilitation and healing on the other. Prison medicine became distinct from traditional practice outside of the prison walls, and this dissertation, through each of its chapters, has told the story of how one American prison evolved that distinctive form of practice.

This dissertation has described ways in which the physician crafted medicine for the prison through a negotiation of the competing objectives he was charged with pursuing. Chapter 1 lays out the history and origins of the Minnesota State Prison at Stillwater. The environment and objectives of the turn-of-the-century American prison

system created an opportunity for officials in the newly-incorporated state to construct a prison that met their objectives. Competing ideas of rehabilitation and prison design in the period between 1850 and 1930 established the conditions in which medicalized notions of reform would evolve, and the evidence of sensitivity to moral reform from the inception of Minnesota State Prison provides a basis for understanding the importance medical practice played within it in the following decades.

Chapter 2 examined medical practice in the prison explicitly, directly addressing the question: how did the prison physician shape medical practice for an inmate population? Physicians who came to Minnesota State Prison quickly discovered that, because of the constraints of the prison environment, they would have to exercise their judgment and ingenuity in new ways. In addressing malingering by inmate-patients, implementing recordkeeping systems, and developing classification schemes for medical diagnosis and labor, the physician confronted the challenges that became the identifying features of his practice.

The discussion of recordkeeping in Chapter 2 feeds into a consideration of inmate demographics in Chapter 3. Part of the reason records provided such a critical tool for prison physicians was the fact that the prison population was defined by its unique demographics. The case of tuberculosis as an endemic disease within the prison demonstrates how the responsibilities of the physician extended beyond the care of individual inmates to the custodianship of the prison population at large, and indicates how this large-scale responsibility gave the physician authority that extended to his influence over matters such as prison design and daily regimen.

Chapter 4 continues to examine the physician's brand of medicine by examining how the physician balanced treatment of mental and physical health issues within the prison. The physician's role in this context was unique. By considering inmates' mental health, confronting criminality as disease, taking on the classification of inmates according to their mental health, the physician grew into his role as the custodian of his patients' moral character. This evolution of the physician's role paved the way for the prison to become a place where the developing field of psychology could claim expertise. Psychologists, in turn, also treated prison as laboratory of clinical practice, while laying the foundation of their maturing field.

Finally, Chapter 5 discusses the care of mental and physical health in the prison in the context of the creation of the hospital for the criminal insane. The early-twentieth century was a time of increased institutional and professional specialization that profoundly influenced the practice of medicine within the prison. As mentally ill inmates were transferred to criminal asylums, the ideal of reformative care went with them. As a result, this transition marks the end of an era for prison medicine.

Each of the chapters uses a population perspective to examine the history of healthcare in the American prison system in the late nineteenth and early twentieth centuries using methods consistent with quantitative history and medical history. In doing so, I hope to contribute a new perspective on the prison as a medical institution. These are not revolutionary methods for medical history, as historians in the 1970s and 1980s used similar methods to examine morbidity, nutrition, and fertility. My goal has been to demonstrate how these methods can be fruitfully applied to historiographical trends that

have emerged since quantitative methods were last in widespread use. The use of medical records for quantitative history opens up a new range of studies, including nutritional and anthropometric research. Medical records are a rich source of both quantitative and qualitative material. Brought together, these dual perspectives can be used to study the health of a population through both macro- and micro-level analyses.

This dissertation calls historical attention to the medical aspects of correctional institutions, and defines these institutions as reformative and rehabilitative, not merely punitive. Of course, not all aspects of health in the prison can be discussed here. I hope this study raises more questions about correctional healthcare than it answers. More case studies of prisons are needed to understand how institutions varied in their therapeutic missions. These would also expose regional, temporal, and philosophical differences in practice of medicine in the prison, the therapeutic missions of the prisons, and the disease profiles of the inmate population they house. The prison is a house of care. By understanding it as such historians have the opportunity to rehabilitate its image as a medical institution.

Bibliography

Secondary Sources

Adler, Helmut E. *Aspects of the History of Psychology in America 1892–1992*. New York: New York Academy of Sciences, 1994.

Allen, Francis A. *The Decline of Rehabilitative Ideal: Penal Policy and Social Purpose.* New Haven: Yale University Press, 1981.

Anderton, Douglas L. and Susan Hautaniemi Leonard. "Grammars of Death: An Analysis of Nineteenth-Century Literal Causes of Death from the Age of Miasmas to Germ Theory." *Social Science History* 28, no. 1 (2004): 111–143.

Annas, George J. and Michael A. Grodin, eds. *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. New York and Oxford: Oxford University Press, 1992.

Arros, Danielle M. *Punishment and Prison Reform: Contributions of a Psychodynamic Approach to American Corrections*. Psy.D. diss., University of Hartford, In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 3163456; accessed Jan 21, 2010).

Alter, George, and Ann Carmichael. "Classifying the Dead: Toward a History of the Registration of Causes of Death." *Journal of the History of Medicine and Allied Sciences* 54 (1999): 114–132.

Ayers, Edward Lynn. *Crime and Society in the Nineteenth-Century South. Ph.D. diss.,* Yale University, 1980. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 8110037; accessed Jan 21, 2010).

Bakan, David. "The Influence of Phrenology on American Psychology." *Journal of the History of Behavioral Sciences* 2 (1966): 200–220.

Barnes, Harry Elmer. "The Historical Origin of the Prison System in America." *Journal of the American Institute of Criminal Law and Criminology* 12, no. 1 (1921): 35–60.

Barrows, Samuel J., ed. *The Reformatory System in the United States*. Washington, DC: Government Printing Office, 1900.

Bartelson, Jens. *The Critique of the State.* Cambridge: Cambridge University Press, 2001.

Becker, Peter and Richard Wetzell. *Criminals and Their Scientists: The History of Criminology in International Perspective*. New York: Cambridge University Press, 2006.

Beemer, Jeffrey K. “Diagnosis Prescriptions: Shifting Boundaries in Nineteenth-Century Disease and Cause-of-Death Classification.” *Social Science History* 33, no. 3 (2009): 307–340.

Beirne, Piers. *Inventing Criminology: Essays on the Rise of Homo Criminalis*. Albany: State University of New York Press, 1993.

Bliss, Michael. *The Making of Modern Medicine: Turning Points in the Treatment of Disease*. Chicago: University of Chicago Press, 2011.

Barzansky, Barbara. *Beyond Flexner: Medical Education in the Twentieth Century*. New York: Greenwood Press, 1992.

Braslow, Joel. *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*. Berkeley: University of California Press, 1997.

Briggs, L. Vernon. *History of the Psychopathic Hospital*, *Boston, Massachusetts*. Boston: Wright & Potter Printing Company, 1922.

Burnham, John C. “Psychiatry, Psychology, and the Progressive Movement.” *American Quarterly* 12 (1960): 457–465.

Camfield, Thomas. “The Professionalization of American Psychology, 1870–1917.” *Journal of the History of the Behavioral Sciences* 9 (1973): 66–75.

Carlson, Elof A. “The Influence of Phrenology on Early American Psychiatric Thought.” *American Journal of Psychiatry* 115 (1958): 535–538.

Chamberlin, Rudolph W. *There is No Truce: A Life of Thomas Mott Osborne*. New York: The Macmillan Company, 1985.

Chambers, John. *The Tyranny of Change: America in the Progressive Era, 1890–1920.* New Brunswick, NJ: Rutgers University Press, 2000.

Clapp, Elizabeth. *Mothers of all Children: Women Reformers and the Rise of Juvenile Courts in Progressive Era America*. University Park, PA: Pennsylvania State University Press, 1998.

Colbert, Charles. *A Measure of Perfection: Phrenology and the Fine Arts in America*. Chapel Hill and London: University of North Carolina Press, 1997.

Colburn, David R. and George E. Pozzetta. *Reform and Reformers in the Progressive Era.* Westport, CT: Greenwood Press, 1983.

Coale, A.J. and S.C. Watkins, eds. *The Decline of Fertility in Europe.* Princeton, NJ: Princeton University Press, 1986.

Cohen, Sal. "The Mental Hygiene Movement, the Development of Personality and the School: The Medicalization of American Education." *History of Education Quarterly* 23 (1983): 123–148.

Converse, Jean. *Survey Research in the United States: Roots and Emergence 1890–1960.* Berkeley: University of California Press, 1987.

Cullen, M. J. *Statistical Movement in Early Victorian Britain.* Hassocks: Harvester Press, 1975.

Calhoun, Christopher ed. *Sociology in America: A History.* Chicago: University of Chicago Press, 2007.

Crenner, Christopher. "Introduction of the Blood Pressure Cuff into U.S. Medical Practice: Technology and Skilled Practice," *Annals of Internal Medicine* 128, no. 6 (1998): 488–493.

Dain, Norman. *Clifford W. Beers: Advocate for the Insane*. Pittsburgh: Pittsburgh University Press, 1980.

Daniel, Thomas M. *Captain of Death: The Story of Tuberculosis*. Rochester, NY: University of Rochester Press, 1997.

Davies, John. *Phrenology: Fad and Science; A 19th-Century American Crusade*. Hamden, CT: Archon Books, 1971.

Delgado, Melvin and Denise Humm-Delgado. *Health and Health Care in the Nation's Prisons: Issues, Challenges, and Policies.* Lanham: Rowman & Littlefield Publishers, 2009.

Dobelbower, Nicholas Colcord. *The Criminal Type: The Articulation of Criminality and Sexuality in Nineteenth-century France*. Ph.D. diss., Duke University, 2001. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 3030960; accessed Jan 21, 2010).

Dolbey, Robert B. *A Regimental Surgeon in War and Prison*. London: John Murray, 1917.

Dubler, N. N. “The Collision of Confinement and Care: End-of-Life Care in Prisons and Jails,” *Journal of Law and Medical Ethics* 26, no. 2 (1998): 149–156.

Dubos, René J. *The White Plague: Tuberculosis, Man, and Society*. New Brunswick, NJ: Rutgers University Press, 1987.

Dunn, James Taylor. “The Minnesota State Prison during the Stillwater Era.” *Minnesota History* (1960), 147–155.

Durkheim, Emile. *The Division of Labor in Society*. Glencoe, Ill.: Free Press, 1947.

Durkheim, Emile. *Professional Ethics and Civic Morals*. London: Routledge & Kegan Paul, Ltd, 1957.

Dwyer, Ellen. *Homes for the Mad: Life Inside Two Nineteenth-century Asylums*. New Brunswick: Rutgers University Press, 1987.

Eastern State Penitentiary of Pennsylvania. *Prison Sentences: The Prison as Site, the Prison as Subject.* Philadelphia: Moore College of Art and Design, 1995.

Engster, Daniel. *Divine Sovereignty: The Origins of Modern State Power*. Dekalb: Northern Illinois University Press, 2001.

Erickson, Paul A. *Phrenology and Physical Anthropology: The George Combe Connection.* Halifax, Nova Scotia, Canada: Saint Mary’s University Press, 1979.

Eriksson, Torsten. *The Reformers: An Historical Survey of Pioneer Experiments in the Treatment of Criminals*. New York: Elsevier, 1976.

Esquith, Stephen L. “Professional Authority and State Power,” *Theory and Society* 16, no. 2 (1987): 237–262.

Evans, Robin. *The Fabrication of Virtue: English Prison Architecture, 1750–1840*. Cambridge: Cambridge University Press, 1982.

Eyler, John. *Victorian Social Medicine: The Ideas and Methods of William Farr.* Baltimore: Johns Hopkins University Press, 1979.

Finger, Stanley. *Minds Behind the Brain: A History of the Pioneers and their Discoveries*. Oxford and New York: Oxford University Press, 2000.

Fiscella, K., N. Pless, S. Meldrum, and P. Fiscella. "Benign Neglect or Neglected Abuse: Drug and Alcohol Withdrawal in US Jails." *Journal of Law, Medicine, and Ethics* 32(2) (2004): 129–136.

Fitzpatrick, Ellen Frances. *Academics and Activists: Women Social Scientists and the Impulse for Reform, 1892–1920*. Ph.D. diss., Brandeis University, 1981. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 8126874; accessed Jan 21, 2010).

Fitzpatrick, Ellen. *Endless Crusade: Women Social Scientists and Progressive Reform.* New York: Oxford University Press, 1990.

Foucault, Michel. *Discipline & Punish: The Birth of the Prison.* New York: Random House, 1995.

Foucault, Michel. *Madness and Civilization.* New York: Vintage Books, 1994.

Floyd, Janet. "Dislocations of the Self: Eliza Farnham at Sing Sing Prison." *Journal of American Studies,* 2 (2006): 311–325.

Freedman, Estelle B. "Uncontrolled Desires': The Response to the Sexual Psychopath, 1920–1960." *Journal of American History* 74: 83–106.

Freedman, Estelle B. *Their Sisters' Keepers: Women's Prison Reform in America, 1830–1930.* Ann Arbor: University of Michigan Press, 1981.

Gabaccia, Donna and Loretta Baldassar. *Intimacy and Italian Migration: Gender and Domestic Lives in a Mobile World* (New York: Fordham University Press, 2010).

Garland, David. *Punishment and Modern Society: A Study in the Social Theories* (Studies in Crime and Justice). Chicago: University of Chicago Press, 1990.

Garland, David. *The Culture of Control: Crime and Social Order in Contemporary Society.* Chicago: University of Chicago Press, 2001.

Gary, Lowe. *The Professionalization of Poverty: Social Work and the Poor in the Twentieth Century*. New York: Aldine de Gruyter, 1999.

Gatton, Stephen. "Criminal Propensities: Psychiatry, Classification, and Imprisionment in New York State 1916–1940." *Social History of Medicine*, 23, no. 1 (2009): 79–97.

Gibson, Mary and Nicole Hahn Rafter, eds. *Criminal Man. (Cesare Lombroso)* Durham: Duke University Press, 2006.

Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* New York: Anchor Books, 1961.

Goldsmith, Larry. "History from the Inside Out: Prison Life in Nineteenth-Century Massachusetts." *Journal of Social History*, 31, no. 1 (1997): 109–125.

Goldsmith, Larry. *Penal Reform, Convict Labor, and Prison Culture in Massachusetts, 1800–1880.* Ph.D. diss., University of Pennsylvania, 1994. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 9521039; accessed Jan 21, 2010).

Goliszek, Andrew. *In the Name of Science: A History of Secret Programs, Medical Research, and Human Experimental.* New York: St. Martins Press, 2003.

Grabner, Jennifer. *The Furnace of Affliction: Prisons & Religion in Antebellum America*. Chapel Hill: University of North Carolina Press, 2001.

Grefe, Christina Morgan. *Museums and Order: 'Truth', Politics, and the Interpretation of America's Historic Prisons.* Ph.D. diss., Brown University, 2005. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 3174613; accessed Jan 21, 2010).

Grob, Gerald. *From Asylum to Community: Mental Health Policy in Modern America.* Princeton: Princeton University Press, 1991.

Grob, Gerald. *Edward Jarvis and the Medical World of the Nineteenth-Century America*. Knoxville: University of Tennessee Press, 1978.

Grob, Gerald. *Mental Illness and American Society*. Princeton: Princeton University Press, 1983.

Grob, Gerald. *The Mad Among Us: A History of Care of America's Mentally Ill*. New York: Free Press, 1994.

Grob, Gerald. *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830–1920.* Chapel Hill: University of North Carolina Press, 1966.

Gollaher, David. *Voice for the Mad: The Life of Dorothea Dix.* New York: Free Press, 1995.

Hamilton, Arthur Stephen. *The Early History of Medicine in Minneapolis*. Minneapolis, 1918.

Handy, A. "Development of the Prison Medical Service 1774–1895." *Clio Medica* 24 (1995): 59–82.

Haskell, Thomas. *The Emergence of Professional Social Science*. Urbana: University of Illinois Press, 1977.

Hawkins, Hugh. *A History of the University Founded by Johns Hopkins.* Baltimore: The Johns Hopkins University Press, 1946.

Herviel, Tara and Paul Wright, eds. *Prison Nation The Warehousing of America's Poor.* New York: Routledge, 2003.

Hesselton, D. *Crisis and Reform at Minnesota's Stillwater Prison, 1960–2000*. Ph.D. diss., University of Minnesota, 2007. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 3287817; accessed Jan 21, 2010).

Hofstadter, Richard. *The Progressive Movement, 1900–1915*. Englewood Cliffs, NJ: Prentice-Hall, 1963.

Horn, David G. *The Criminal Body: Lombroso and the Anatomy of Deviance*. New York and London: Routledge, 2003.

Hornblum, Allen. "Subjected to Medical Experimentation: Pennsylvania's Contribution to 'Science' in Prisons." *Pennsylvania History* 67, no. 3 (2000): 415–426.

Hornblum, Allen. *Acres of Skin: Human Experiments at Holmesburg Prison*. New York: Routledge, 1998.

Joel Howell. *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century*. Baltimore: Johns Hopkins University Press, 1995.

Hunter, Ian and Safiv Saunders, eds. *Natural Law and Civil Sovereignty: Moral Right and State Authority in Early Modern Political Thought*. New York and Basingstoke: Palgrave/Macmillan, 2002.

Jackson-Retondo, Elaine. "Manufacturing Moral Reform: Images and Realities of a Nineteenth-Century American Prison." *Perspectives in Vernacular Architecture*, 8 (2000): 117–137.

Johnston, Norman. *Forms of Constraint: A History of Prison Architecture*. Urbana, IL: University of Illinois Press, 1998.

Johnston, Norman. *The Human Cage: A Brief History of Prison Architecture.* New York: The American Foundation, 1973.

Jones, James. *Bad Blood: The Tuskegee Syphilis Experiment*. New York: Free Press, 1981.

Klein, Philip. *Prison Methods in New York State, a Contribution to the Study of the Theory and Practice of Correctional Institutions in New York State*. New York: Columbia University, 1920.

Komlos, John. "An Anthropometric History of Early-Modern France, 1666–1766". *European Review of Economic History* (2003): 159–189.

Komlos, John. "The Height and Weight of West Point Cadets: Dietary Change in Antebellum America." *Journal of Economic History* 47 (1987): 897–927.

Komlos, John. "Nutrition and Economic Development in Post-Reconstruction South Carolina: an Anthropometric Approach." *Social Science History* 19 (1995): 91–116.

Komlos, John. *Nutrition and Economic Development in the Eighteenth-Century Habsburg Monarchy: An Anthropometric History*. Princeton, NJ: Princeton University Press, 1989.

Klips, Stephen Anthony. *Institutionalizing the Poor: The New York City Almshouse, 1825–1860.* Ph.D. diss, City University of New York, 1980. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 8104103; accessed Jan 21, 2010).

Kunzel, Regina. *Criminal Intimacy: Prison and the Uneven History of Modern American Sexuality*. Chicago: University of Chicago Press, 2008.

Kunzel, Regina. *Fallen Women, Problem Girls: Unmarried Mothers and the Professionalization of Social work 1890–1945*. New Haven, CT: Yale University Press, 1993.

Kutch, J. M. Jr. "The Federal Prisons' Mental Health Program 1930–1985." *Journal of Mental Health and Administration* 14 (1987): 20–25.

Lederer, Susan. *Subjected to Science: Human Experimentation in America Before the Second World War*. Baltimore: Johns Hopkins University Press, 1995.

Lewis, Orlando Faulkland. *The Development of American Prisons and Prison Customs, 1776–1845 with Special Reference to Early Institutions in the State of New York*. Albany: Prison Association of New York, 1922.

Linder, J. F. and F. J. Meyers. "Palliative Care for Prison Inmates: 'Don't Let Me Die in Prison." *Journal of the American Medical Association* 298, no. 21 (2007): 2481.

Ludmerer, Kenneth M. *Learning to Heal: The Development of American Medical Education*. New York: Basic Books, 1985.

Ludmerer, Kenneth M. *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. New York: Oxford University Press, 1999.

Lyon, Sherrie. *Species, Serpents, Spirits, and Skulls: Science at the Margins of the Victorian Age.* Albany: SUNY Press, 2009.

McCaldon, R. J., G. N. Conacher, and B. J. Clark. "The Right to Remain Psychotic." *Canadian Medical Association Journal* 145, no. 1 (1991): 777–781.

McKeown, Thomas. *The Modern Rise of Population*. London: Edward Arnold, 1976.

McRorie, Higgins P. "Genitourinary medicine and surgery in prisons during the period of reform." *BJU International* 95 (2005): 1192–1195.

Meranze, Michael. *Laboratories of Virtue: Punishment, Revolution, and Authority in Philadelphia, 1760–1835*. Chapel Hill: University of North Carolina Press, published for Institute of Early American History and Culture, 1996.

McKinney, Nancy. "Eliza W. Farnham (November 17, 1815 – December 15, 1864)" in *Early American Nature Writers*. Westport, CT: Greenwood Press, 2007.

Miller, Char Roone. *Tailored Citizenship: State Institutions and Subjectivity*. Westport, CT and London: Praeger, 2002.

Murton, Thomas O. *The Dilemma of Prison Reform*. New York: Holt, Rinehart, and Winston, 1976.

Myers, J. Arthur. *Invited and Conquered: A Historical Sketch of Tuberculosis in Minnesota.* Saint Paul: Webb, 1949.

National Congress on Penitentiary and Reform Discipline. *Transactions of the National Congress on Penitentiary and Reformatory Discipline Held at Cincinnati, Ohio, October 12–18, 1870.* Albany: Weed, Parsons, 1871.

Niveau. G. “Relevance and Limits of the Principle of ‘Equivalence of Care’ in Prison Medicine.” *Journal of Medical Ethics* 33 (2007): 610–613.

Numbers, Ronald L. “William Beaumont and the Ethics of Human Experimentation.” *Journal of the History of Biology*, 12, no. 1 (1979): 113–135.

Nye, Robert. *Crime, Madness, & Politics in Modern France: The Medical Concept of National Decline*. Princeton, NJ: Princeton University Press, 1984.

Piscotta, Alexander. *Benevolent Repression: Social Control and the American Reformatory-Prison Movement*. New York: New York University Press, 1994.

Prior, P. M. “Mad, Not Bad: Crime, Mental Disorder, and Gender in 19th Century Ireland.” *History of Psychiatry* 8 (1997): 501–16.

Radelet, M. L. and G. W. Barnard. “Treating Those Found Incompetent for Execution,” *Bulletin of the American Academy of Psychiatry and Law* 16, no. 4 (1988): 297–308.

Rafter, Nicole Hahn. *The Criminal Brain: Understanding Biological Theories of Crime*. New York: New York University Press, 2008.

Rafter, Nicole. *The Origins of Criminology: A Reader*. New York and London: Routledge, 2009.

Rasmussen, O. V. “The Involvement of Medical Doctors in Prison Torture: The State of the Art.” *Journal of Medical Ethics* 17 (1991): 26–28.

Recchiuti, John. *Civic Engagement: Social Science and Progressive-era Reform in New York City*. Philadelphia: University of Pennsylvania Press, 2007.

Rennie, Ysabel. *The Search for the Criminal Man: A Conceptual History of the Dangerous Offender*. Lexington, MA: Lexington Books, 1978.

Richardson, Theresa. *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada*. Albany: State University of New York Press, 1989.

Roberts, Leonard Harold. *A History of Inmate Rehabilitation Through Education in the Florida State Correctional System: 1868–1980.* Ph.D. diss., University of Florida, 1981. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 8213694; accessed Jan 21, 2010).

Robinson, Louis N. *Penology in the United States*. Philadelphia: The John C. Winston Co., 1921.

Rock, Paul. *Reconstructing a Women's Prison: The Holloway Redevelopment Project, 1968–88*. Oxford: Clarendon Press, 1996.

Rosenberg, Charles E. *The Care of Strangers: The Rise of America's Hospital System*. New York: Basic Books, Inc. Publishers, 1987.

Rosenberg, Charles. "And Heal the Sick: The Hospital and the Patient in 19th Century America." *Journal of Social History* 10, no. 4 (1977): 428–447.

Rosenberg, Charles E. "Institutionalized Ambiguity: Conflict and Continuity in the American Hospital." *Second Opinion* 12 (1989): 62–73.

Rosenberg, Charles E. "Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880–1920." *Bulletin of the History of Medicine* 53 (1979): 346–391.

Rosenberg, Charles. *No Other Gods: On Science and American Social Thought.* Baltimore: Johns Hopkins University Press, 1976.

Rosner, David. *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915*. Cambridge: Cambridge University Press, 1982.

Rothman, David J. *Conscience and Convenience: the Asylum and its Alternatives in Progressive America.* New York: Aldine de Gruyter, 2002.

Rothman, David J. *The Discovery of the Asylum: Social Order and Disorder in the New Republic.* New York: Aldine de Gruyter, 2002.

Rothman, Shelia. *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in America*. New York: Basic Books, 1994.

Rotman, Edgardo. *Beyond Punishment: A New View on the Rehabilitation of Criminal Offenders*. Westport, CT: Greenwood Press, 1990.

Ruggles, Steven. "Fallen Women: The Inmates of the Magdalen Society Asylum of Philadelphia, 1836–1908." *Journal of Social History* 16, no. 4 (1983): 65–82.

Ruggles, Steven, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

Sagan, L. A. and A. Jonsen. "Medical Ethics and Torture in Prisons." *New England Journal of Medicine* 294, no. 26 (1976): 1427–1430.

Saros, Daniel Earl. *Labor, Industry, and Regulation during the Progressive Era.* New York: Routledge, 2009.

Saunders, J. F. "Criminal Insanity in the 19th Century Asylums." *Journal of the Royal Society of Medicine* 81 (1988): 73–75.

Schaefer, Kurt Kim. *A Case Study in the Failure of Nineteenth-century Penal Reform: John Morris and the Investigation of 1875.* M.A. diss., Michigan State University, 1991. In Dissertations & Theses: A&I [database online]; available from http://www.proquest.com (publication number AAT 1352743; accessed Jan 21, 2010).

Scranton, Phil and Jude McCulloch. *The Violence of Incarceration*. New York: Routledge, 2009.

Sim, J. "The Prison Medical Services and the Deviant 1895–1948." *Clio Medica* 35 (1995): 102–117.

Smith, R. "History of the Prison Medical Services." *British Medical Journal* (Clinical ed.) 287 (1983): 1786–1788.

Smith, R. "History Services for Prisoners: Lost in Ambiguities." *Clio Medica* 34 (1995): 134–150.

Sparks, Richard, Anthony E. Bottoms, and Will Hay. *Prison and the Problem of Order.* Oxford: Clarendon Press, 1996.

Stanley, Finger. *Minds Behind the Brain: A History of the Pioneers and their Discoveries*. Oxford: Oxford University Press, 2000.

Staples, William G. "In the Interest of the State: Production Politics in the Nineteenth-century Prison," *Sociological Perspectives* 33 (1990): 375–395.

Sullivan, Robert R. "The Birth of the Prison: the Case of Benjamin Rush." *Eighteenth Century Studies*, 31, no. 3 (1998): 333–334.

Teeters, Negley K. "The Pennsylvania Prison Society: A Century and a Half of Penal Reform." *Journal of Criminal Law and Criminology*, 28, no. 3 (1937): 374–379.

Tomes, Nancy. *The Art of Asylum Keeping: Thomas Story Kirkbride and the Origins of American Psychiatry*. Philadelphia: University of Pennsylvania Press, 1994.

Tomlinson, Stephen. *Head Masters: Phrenology, Secular Education, and Nineteenth-Century Social Thought*. Tuscaloosa: University of Alabama Press, 2005.

Tracy, Sarah. *Alcoholism in America: From Reconstruction to Prohibition*. Baltimore: Johns Hopkins University Press, 2005.

Van Wyhe, John. *Phrenology and the Origins of Victorian Scientific Naturalism.* Burlington, VT: Ashgate Publishing Company, 2004.

Vaughn, M. S. "Penal Harm Medicine: State Tort Remedies for Delaying and Denying Health Care to Prisoners." *Crime, Law, and Social Change* 31, no. 4 (1999): 273–302.

Vogel, Morris. *The Invention of the Modern Hospital: Boston, 1870–1930*. Chicago: University of Chicago Press, 1985.

Wetzell, Richard. *Inventing the Criminal: A History of German Criminology, 1880–1945*. Chapel Hill and London: University of North Carolina Press, 2000.

Wheatley, Steven Charles. *The Politics of Philanthropy: Abraham Flexner and Medical Education*. Madison, WI: University of Wisconsin Press, 1988.

Wiener, M.J. "The Health of Prisoners and the Two Faces of Benthamism." *Clio Medica* 34 (1995): 44–58.

Wilson, Leonard. *Medical Revolution in Minnesota: A History of the University of Minnesota Medical School.* Saint Paul, MN: Midewiwin Press, 1989

Yanni, Carla. *The Architecture of Madness; Insane Asylums in the United States. Minneapolis: University of Minnesota Press*, 2007.

Zenderland, Leila. *Measuring Minds: Henry Herbert Goddard and the Origins of American Intelligence Testing*. Tomes, (Cambridge: Cambridge University Press, 1988).

Primary Sources

Adler, H. "Psychiatry as Applied to Criminology in the United States," *Journal of Criminal Law and Criminology*, 24 (1933): 50–51.

Akers, Elmer R. "Classification in the State Prison." *Journal of Criminal Law and Criminology* 34, no. 1 (May/June 1943): 16–25.

Anderson, V.V. "The Laboratory in the Study and Treatment of Crime." *Journal of the American Institute of Criminal Law and Criminology* 5, no. 6 (March 1915): 840–850.

Anderson, Victor V. "The Psychiatric Clinic in the Treatment of Conduct Disorders of Children and the Prevention of Juvenile Delinquency." *Journal of the American Institute o Criminal Law and Criminology* 14, no. 4 (Feb 1924): 414–456.

"Annual Message of Governor Alexander Ramsey." *Journal of the House of Representatives of the Legislative Assembly of the Territory of Minnesota*. Saint Paul: J.M. Goodhue, 1853.

Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending Nov. 30, 1875. Saint Paul, MN: Pioneer-Press Company, 1876.

Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1869. Saint Paul, MN: Press Printing Company, 1870.

Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1870. Saint Paul, MN: Press Printing Company, 1871.

Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Fiscal Year Ending November 30, 1872. Saint Paul, MN: Saint Paul, Press Printing Company, 1873.

Annual Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota Session of 1865. Saint Paul, MN: Frederick Driscoll, State Printer, 1865.

Annual Report of the Inspectors of the State Prison of the State of Michigan for the year 1857. Lansing: Hosmer & Kerr, Printers to the State, 1858.

Annual Report of the Inspectors of the State Prison of the State of Michigan for the Year 1862. Lansing: John A. Kerr & Co, Printers to the State, 1862.

Annual Report of the Inspectors of the State Prison of the State of Michigan for the Year closing Sept. 30, 1874. Lansing: W.S. George & Co., State Printers and Binders, 1875.

Annual Report of the Inspectors of the State Prison of the State of Michigan for the Year closing Sept. 30, 1879. Lansing: W.S. George & Co., State Printers and Binders, 1880.

Argow, Walter Webster. "The Efficacy of Prison Mental Tests as a Guide to Rehabilitation." *Journal of Criminal Law and Criminology* 26, no. 6 (March/April 1934): 1074–1080.

"A Statistical System for the Use of Institutions for Criminals and Delinquents (Report of Committee 'J' of the Institute." *Journal of the American Institute of Criminal Law and Criminology* 11, no. 3 (Nov. 1920): 440–452.

Battaglini, Giulio Q. and Robert W. Millar. "Eugenics and the Criminal Law." *Journal of the American Institute of Criminal Law and Criminology* 5, no. 1 (May 1914): 12–15.

Bertillon, Alphonse. "The Bertillon System of Identification." *The Forum* 11 (1891): 330–341.

Biennial Report of the Inspectors and Warden of the State Prison to the Legislature of Minnesota for the Two Years Ending November 30th, 1880. Saint Peter, MN: J. K. Moore, State Printer, 1881.

Bowers, Paul E. "Criminal Anthropology." *Journal of the American Institute of Criminal Law and Criminology* 5, no. 3 (September 1914): 358–363.

Bowers, Paul E. "The Dangerous Insane." *Journal of the American Institute of Criminal Law and Criminology* 12, no. 3 (November 1921): 369–380.

Brigham, Amariah. "'Journal of Prison Discipline,' and Lunatic Asylums." *American Journal of Insanity* 2 (October 1845): 175–183.

Browne, J. H. Balfour. *The Medical Jurisprudence of Insanity*. San Francisco: Sumner Whitney & Co., 1880.

Buchanan, Joseph Rodes. *Outlines of Lectures on the Neurological System of Anthropology, as Discovered, Demonstrated and Taught in 1841 and 1842*. Cincinnati: Printed at the Office of Buchanan's Journal of Man, 1854.

Burr, Charles W. "Crime from a Psychiatrist's Point of View." *Journal of the American Institute of Criminal Law and Criminology* 16, no. 4 (February 1926): 537–554.

Buttolph, H. A. “On the Physiology of the Brain and its Relation in Health and Disease to the Faculties of the Mind.” *American Journal of Insanity* 42 (January 1886): 277–316.

Buttolph, H. A. “Relation Between Phrenology and Insanity.” *American Journal of Insanity* 6 (October 1849): 127–136.

Caldwell, Charles. “New Views of Penitentiary Discipline and Moral Education through Reformation of Criminals.” *Phrenological Journal* 7 (1882): 384–410 and 493–517.

Caldwell, Charles. “Phrenology Vindicated Against the Charges of Fatalism.” *American Phrenological Journal and Miscellany* 2, (December 1839): 98–110.

Caldwell, Charles. “Thoughts on the Most Effective Condition of the Brain as the Organ of the Mind, and on the Modes of Attaining It.” *American Phrenological Journal and Miscellany* 1 (August 1839): 393–430.

Caldwell, Charles. “Thoughts on the True Connexion of Phrenology and Religion.” *American Phrenological Journal and Miscellany* 1 (June 1839): 324–330.

Caldwell, Charles. *Elements of Phrenology*. Lexington, KY: A. G. Meriwether, 1827 [1824].

Caldwell, Charles. The *Autobiography of Charles Caldwell*. Philadelphia: Lipincott, Grambo and Co., 1855.

Chaneles, Sol, ed. *Prisons and Prisoners: Historical Documents.* New York: Haworth Press, 1985.

“Character of La Blanc Murderer.” *American Phrenological Journal and Miscellany* 1 (December 1838): 89–96.

“Cole Younger’s Own Account of the Northfield Raid, as Told to Dr. A. E. Hedback, Prison Physician at Stillwater in 1897, Is Now Published for First Time.” *The Minneapolis Tribune*, November 21, 1915, p. C5.

Combe, George. “Remarks on the Principles of Criminal Legislation, and the Practice of Prison Discipline.” Bristol Selected Pamphlets, 1854.

Combe, George. *A System of Phrenology*. Boston: Marsh, Capen, and Lyon, 1838.

Combe, George. *Elements of Phrenology,* Third Edition. Edinburgh: John Anderson, 1828.

Combe, George. *Lectures of Phrenology; Including its Application to the Present and Prospective Condition of the United States: with Notes, and Introductory Essay, and an Historical Sketch by Andrew Boardman*. New York: Published by Samuel Colman, 1839.

"Comparison of the Physical Condition of Prisoners on Admission and Discharge." *Journal of the American Institute of Criminal Law and Criminology* 9, no. 1 (May 1918): 128.

Cotton, Henry A. *The Defective Delinquent and Insane.* Princeton: Princeton University Press, 1921.

"Courses in Criminology and Mental Hygiene." *Journal of the American Institute of Criminal Law and Criminology* 13, no. 2 (Aug 1922): 279–280.

"Criminal Lunacy." *The Medical and Surgical Reporter: A Weekly Journal* 46 (January-July 1883): 526–528.

"Criminal Responsibility." *Journal of the American Institute of Criminal Law and Criminology* 13, no. 1 (May 1922): 126.

Dean, Amos. *Lectures on Phrenology: Delivered Before the Young Men's Association for Mutual Improvement of the City of Albany.* Albany: Oliver Steele, and Hoffman & White, 1834.

E. P. Fowler, trans. Benedikt, Moriz. *Anatomical Studies Upon Brains of Criminals: A Contribution to Anthropology, Medicine, Jurisprudence, and Psychology.* New York: W. Wood, 1881.

East, W. Norwood. *The Relation of the skull and brain to crime.* Edinburgh: Oliver and Boyd, 1928.

Eighteenth Biennial Report of the Minnesota State Prison (1913–1914). Stillwater, MN: The Mirror, 1914.

Eighth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending July 31, 1894. Saint Paul, MN: Pioneer Press Company, 1894.

Eighth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota. For the Biennial Period Ending July 31, 1898. Minneapolis: Harrison & Smith, Printers, 1899.

Eleventh Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions. For the year 1926. Boston: Wright & Potter Printing Co., State Printers, 1927.

Eleventh Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Ending July 31, 1900. Minneapolis, MN: Price Brothers Co., 1900.

Eleventh Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1922, to June 30, 1924. Sacramento, CA: California State Printing Office, 1924.

"The Field of the Prison Physician." *Journal of the American Institute of Criminal Law and Criminology* 5, no. 6 (March 1915): 921–923.

Fifteenth Biennial Report of the Minnesota State Prison (1907–1908). Stillwater, MN: The Mirror Office, 1909.

"Fire Strikes Stillwater Prison." *The Daily Globe*. Saint Paul, MN. January 27, 1884.

"First Annual Report of the Board of Commissioners." *Journal of the House of Representatives of the Legislative Assembly of the Territory of Minnesota*. Saint Paul: J.M. Goodhue,1852.

Fifth Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions. For the year 1920. Boston: Wright & Potter Printing Co., State Printers, 1921.

Fifth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1910 to June 30, 1912. Sacramento, CA: State Printing, 1912.

Fifth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota for the Biennial Period Ending July 31, 1892. Minneapolis: Harrison & Smith, Printers, 1893.

"Five Years in Prison." *The Minneapolis Tribune*, September 15, 1899, p. 7.

Flexner, Abraham. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*. Boston: D.B. Updike, the Merrymount Press: 1910.

First Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions. For the year 1916. Boston: Wright & Potter Printing Co., State Printers, 1917.

Fourteenth Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions. For the year 1929. Boston: Wright & Potter Printing Co., State Printers, 1930.

Fourteenth Biennial Report of the Minnesota State Prison (1905–1906). Stillwater, MN: The Mirror Office, 1907.

Fourteenth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1928 to June 30, 1930. Sacramento, CA: California State Printing Office, 1930.

Fourth Biennial Report of the Inspectors and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1886. Saint Paul, MN: The Pioneer Press Company, 1886.

Fourth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1908 to July 30, 1910. Sacramento, CA: W.W. Shannon, Superintendent State Printing, 1910.

Fourth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota for the Biennial Period Ending July 31, 1888. Minneapolis: Harrison & Smith, Printers, 1889.

Fourth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota for the Biennial Period Ending July 31, 1890. Minneapolis: Harrison & Smith, Printers, 1891.

Fowler, Orson Squire. *New Illustrated Self-Instructor in Phrenology and Physiology: With Over One Hundred Engravings: Together with the Chart and Character.* New York: S.R. Wells & Co., 1880.

General Laws of the State of Minnesota Passed During the First Session of the State Legislature. Saint Paul: Earle Goodrich, State Printer, Pioneer and Democrat Office, 1858.

General Laws of the State of Minnesota Passed During the Seventh Session of the State Legislature, Commencing January Third, One Thousand Eight Hundred and Sixty-Five, and Terminating March Third, One Thousand Eight Hundred and Sixty-Five. Together with the Joint Resolutions and Reports of the State

Treasurer. Saint Paul: Frederick Driscoll, State Printer, Press Printing Company, 1865.

General Laws of the State of Minnesota Passed During the Ninth Session of the State Legislature. Saint Paul, MN: Pioneer Printing Company, 1867.

Gross, Hans. *Criminal Psychology: A Manual for Judges, Practitioners, and Students*. Boston: Little, Brown, and Company, 1911.

Healy, W. *The Individual Delinquent: A Text-Book of Diagnosis and Prognosis for All Concerned in Understanding Offenders*. Boston: Little, Brown, 1915.

Hyde, Robert Wells. *Experiencing the Patient's Day; A Manual for Psychiatric Hospital Personnel.* New York: Putnam, 1955.

"The Importance of and Up-to-Date Medical Department in a Penal Institution." *Journal of the American Institute of Criminal Law and Criminology* 4, no. 6 (March 1914): 899–904.

Index to the Reports of the National Prison Association, 1870, 1873, 1874, 1883–1904. (Complied by Mary V. Titus, with Introduction by Eugene Smith). Washington: Government Printing Office, 1906.

Joint Documents of the State of Michigan for the State of Michigan for the year 1863. Lansing: John A. Kerr & Co, Printers to the State, 1862.

Livingston, Edward. *A System of Penal Law for the United States of America: Consisting of A Code of Crimes and Punishments; A Code of Procedure in Criminal Cases; A Code of Prison Discipline; and A Book of Definitions*. Washington, DC: Gales & Seaton, 1828.

Mann, Edward C. *A Manual of Psychological Medicine and Allied Nervous Diseases. Containing the Description, Etiology, Diagnosis, Pathology, and Treatment of Insanity with Especial Reference to the Clinical Features of Mental Diseases, and the Allied Neuroses and its Medico-Legal Aspects, with a Carefully Prepared Digest of the Lunacy Laws in the Various States Relating to the Care, Custody, and Responsibility of the Insane.* Philadelphia: P. Blakiston, Son & co, 1883. (Chapter: "Psychology of Crime")

"Medicine and Crime." *Journal of the American Institute of Criminal Law and Criminology* 6, no. 1 (May 1915): 111–112.

Mercier, Charles. *The Jurisprudence of Crime: Medical Biological, and Psychological*. New York: Henry Holt and Company, 1919.

Minnesota Pioneer, June 27, 1850.

Minnesota Pioneer, July 11, 1850.

Minnesota Pioneer, Jan 30, 1851.

Nineteenth Biennial Report of the Minnesota State Prison (1915–1916). Stillwater, MN: The Mirror, 1917.

Ninth Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1896. Saint Paul, MN: Pioneer Press Company, 1896.

Ninth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1918, to June 30, 1920. Sacramento, CA: California State Printing Office, 1920.

Osborne, Thomas Mott. *Within Walls Being a Narrative Personal Experience During A Week of Voluntary Confinement in the State prison at Auburn, New York*. New York: D. Appleton, 1914.

"The Penitentiary." The *Minneapolis Tribune*, May 23, 1875, p. 2.

"Phrenological Developments and Character of Peter Robinson, Who Was Executed April 16th, at New Brunswick, NJ, for the Murder of A. Suydam, Esq." *American Phrenological Journal and Miscellany* 3, (July 1841): 452–459.

"Phrenological Developments and Character of William Miller, Who Was Executed at Williamsport, Pa., July 27th 1838, for the Murder of Solomon Hoffman." *American Phrenological Journal and Miscellany* 1, (May 1839): 272–286.

"Phrenological Examination of Prisoners." *American Phrenological Journal and Miscellany* 3, (November 1840): 83–85.

"Prison Experts Will Discuss Crime Phases." *The Minneapolis Tribune*, September 27, 1914, B5.

Proceedings of the Annual Congress of the American Prison Association, Baltimore, Maryland, November 9 to 14, 1912. Indianapolis: Wm. B. Burford, Printer, 1913.

Proceedings of the Annual Congress of the American Prison Association. Oakland, California, October 9 to 14, 1915. Indianapolis: Wm. B. Burford, Printer, 1916.

Proceedings of the Annual Congress of the National Prison Association of the United States Held at Cincinnati, September 25–30, 1890. Pittsburgh: Shaw Brothers, printers (10 and 12 sixth street), 1891.

Proceedings of the Annual Congress of the National Prison Association of the United States Held At Philadelphia, Pennsylvania, September 13–17, 1902. Pittsburgh: Shaw Brothers, 1903.

Proceedings of the Annual Congress of the National Prison Association of the United States held at Toronto, September 10–15, 1887. Chicago: Knight & Leonard Co., Printers, 1889.

Proceedings of the Annual Congress of the National Prison Association of the United States, Held at Louisville, Kentucky, October 3–8, 1903. Pittsburgh: Shaw Brothers, Printers, 1904.

Proceedings of the Annual Congress of the National Prison Association of the United States, Held at Nashville, November 16–20, 1889. Chicago: Knight & Leonard Co., Printers, 1890.

Proceedings of the Annual Congress of the National Prison Association of the United States, Held At Saint Paul, Minn., June 16–20, 1894. Pittsburgh: Shaw Brothers, Printers, 1894.

"Proceedings of the Fourth Annual Meeting of the Institute." *Journal of the American Institute of Criminal Law and Criminology* 3, no. 4 (November 1912): 592–607.

Proceedings of the National Prison Congress Held at Atlanta, GA, 1886. Chicago: R.R. Donnelley & Sons, The Lakeside Press, 1887.

"Program for Sociology Course 104. State Care of Dependents, Defectives, and Delinquents in Minnesota." *Journal of the American Institute of Criminal Law and Criminology* 7, no. 2 (July 1916): 304–306.

"Psychology in a Juvenile Court." *Journal of the American Institute of Criminal Law and Criminology* 3, no. 4 (November 1912): 617–618.

Public Documents of Massachusetts Being the Annual Reports of Various Public Officers and Institutions for the Year 1896. Boston: Wright & Potter Printing Co., State Printers, 1897.

Public Documents of Massachusetts Being the Annual Reports of Various Public Officers and Institutions for the Year 1897. Boston: Wright & Potter Printing Co., State Printers, 1898.

Public Documents of Massachusetts Being the Annual Reports of Various Public Officers and Institutions for the Year 1900. Boston: Wright & Potter Printing Co., State Printers, 1901.

Public Documents of Massachusetts Being the Annual Reports of Various Public Officers and Institutions for the Year 1911. Boston: Wright & Potter Printing Co., State Printers, 1912.

R. Willis, trans. Spurzheim, Johann Gaspar. *The Anatomy of the Brain, with a General Overview of the Nervous System.* Boston: Marsh, Capen & Lyon, 1834. (First American edition; revised by Charles H. Stedman)

Rector, Frank L. (for society for the control of cancer). *Cancer, Cause, Diagnosis, Control. (*Pamphlet). Indianapolis: Indiana State Board of Health, 1937.

Rector, Frank L. *Cancer Survey of Colorado*. New York: American Society for the Control of Cancer, 1931.

Rector, Frank L. *Cancer Survey of Illinois*. New York: American Society for the Control of Cancer, 1936.

Rector, Frank L. *Cancer Survey of Kansas*. New York: American Society for the Control of Cancer, 1933.

Rector, Frank L. *Cancer Survey of Michigan*. New York: American Society for the Control of Cancer, 1935.

Rector, Frank L. *Cancer Survey of Minnesota*. New York: American Society for the Control of Cancer, 1932.

Rector, Frank L. *Cancer Survey of Nebraska*. New York: American Society for the Control of Cancer, 1934.

Rector, Frank L. *Cancer Survey of Saint Louis County, Missouri*. New York: American Society for the Control of Cancer, 1931.

Rector, Frank L. *Cancer Survey of Wisconsin*. New York: American Society for the Control of Cancer, 1931.

Rector, Frank L. *Health Education: Supplement to Committee Report Covering Paper and Discussion at the Pittsburgh Convention, November 8, 1922.* New York: National Personnel Association, 1922.

Rector, Frank L. *Hard Water and Health*. New York: A.R. Elliott Pub. Co., 1916.

Rector, Frank L. *Physical Examination of Industrial Workers: Results of an Investigation by the Conference Board of Physicians in Industry*. Chicago: American Medical Association, 1920.

Rector, Frank L. *The Story of Cancer for High Schools*. New York: American Society for the Control of Cancer, 1933.

Rector, Frank L. *Underground Waters for Commercial Purposes*. New York: John Wiley & Sons, 1913.

Rector, Frank L. *Health and Medical Service in American Prisons and Reformatories*. New York: The National Society of Penal Information, Inc., 1929.

"Report of Physician and Psychologist on the Reformatory Population at St. Cloud, Minn." *Journal of the American Institute of Criminal Law and Criminology* 4, no. 3 (September 1913): 420–421.

"Report on the Insane." *Eleventh Census.* Washington: US Census Bureau, 1890.

"Science and False Insanity." *The Chicago Tribune*, 5 March 1899, Part 5, p. 45.

"The Scientific Study of Delinquents in Minneapolis." *Journal of the American Institute of Criminal Law and Criminology* 3, no. 5 (January 1913): 781–783.

Second Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1904 to July 30, 1906. Sacramento, CA: W.W. Shannon, Superintendent State Printing, 1906.

Seventeenth Biennial Report of the Minnesota State Prison (1911–1912). Stillwater, MN: The Mirror, 1912.

Seventh Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1914 to June 30, 1916. Sacramento, CA: State Printing, 1916.

Seventh Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota for the Biennial Period Ending July 31, 1896. Minneapolis: Harrison & Smith, Printers, 1897.

Sixteenth Biennial Report of the Minnesota State Prison (1909–1910). Stillwater, MN: The Mirror Office, 1910.

Sixth Annual Report of the Bureau of Prisons of Massachusetts, Including Reports Upon All Prison Matters; with Statistics of Arrests and of Criminal Prosecutions for the year 1921. Boston: Wright & Potter Printing Co., State Printers, 1922.

Sixth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1912 to June 30, 1914. Sacramento, CA: State Printing, 1914.

Sixth Biennial Report of the State Board of Control of Minnesota for the Period Ending July 31, 1912. Minneapolis: Syndicate Printing Co, 1912.

Sixth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota for the Biennial Period Ending July 31, 1894. Minneapolis: Harrison & Smith, Printers, 1895.

Spalding, Edith R. *Experimental Study of Psychopathic Delinquent Women*. New York: Rand McNally, 1923.

Special Report of the Board of Inspectors of the Minnesota State Prison on the Subject of Convict Labor. Minnesota: J.W. Cunningham, State Printer, 1889.

"Special Reports, Physicians Schedule, Insane and Feeble–Minded." Washington: US Census Bureau, 1880.

State of Minnesota Legislature. *Annual Report of the Warden of the State Prison for 1860*. Saint Paul, MN: William R. Marshall, State Printer, 1861.

"Sterilization of Criminals and Defectives." *Journal of the American Institute of Criminal Law and Criminology* 4, no. 3 (September 1913): p. 420.

"Syphilis and its Treatment in a Reformatory for Women." *Journal of the American Institute of Criminal Law and Criminology* 9, no. 2 (August 1918): 276–279.

"Syphilis and Society." *Journal of the American Institute of the American Institute of Criminal Law and Criminology* 8, no. 3 (September 1917): 449–450.

"Syphilis as a Factor in Cause of Insanity." *Journal of the American Institute of Criminal Law and Criminology* 8, no. 3 (September 1917): 448–449.

Tenth Biennial Report of the Board of Managers and Warden of the State Prison to the Governor of Minnesota for the Two Years Endings July 31, 1898. Stillwater, MN: The Prison Mirror, 1898.

Tenth Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1920, to June 30, 1922. Sacramento, CA: California State Printing Office, 1922.

Tenth Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota. For the Biennial Period Ending July 31, 1900. Minneapolis: Harrison & Smith, Printers, 1901.

Third Biennial Report of the State Board of Charities and Corrections of the State of California from July 1, 1906, to July 30, 1908. Sacramento, CA: W.W. Shannon, Superintendent State Printing, 1908.

Third Biennial Report of the State Board of Corrections and Charities to the Legislature of Minnesota. For the Biennial Period Ending July 31, 1886. Minneapolis: Harrison & Smith, Printers, 1887.

Thirteenth Biennial Report of the Minnesota State Prison (1903–1904). Stillwater, MN: The Mirror Print, 1905.

Twelfth Biennial Report of the Minnesota State Prison (1901–1902). Stillwater, MN: The Prison Mirror Print, 1903.

Twentieth Biennial Report of the Minnesota State Prison (1917–1918). Stillwater, MN: The Mirror, 1918.

Twenty-fifth Biennial Report of the Minnesota State Prison (1927–1928). Stillwater, MN: Prison Printing Department, 1928.

Twenty-first Biennial Report of the Minnesota State Prison (1919–1920). Stillwater, MN: The Mirror Print, 1920.

Twenty-forth Biennial Report of the Minnesota State Prison (1925–1926). Stillwater, MN: Prison Printing Department, 1926.

Twenty-second Biennial Report of the Minnesota State Prison (1921–1922). Stillwater, MN: Prison Printing Department, 1922.

Twenty-sixth Biennial Report of the Minnesota State Prison (1929–1930). Stillwater, MN: Prison Printing Department, 1930.

Twenty-third Biennial Report of the Minnesota State Prison (1923–1924). Stillwater, MN: Prison Printing Department, 1924.

"Uniform Statistics in Institutions for Mental Diseases." *Journal of the American Institute of Criminal Law and Criminology* 10, no. 1 (May 1919): 148–149.

United States Census Bureau. *Manual of International Classification of Causes of Death*. Washington, D.C.: U.S. Department of Commerce and Labor, 1902.

United States Treasury Department and United States Public Health Service. *Selected Papers on the Medical Services in the Federal Prison System with Special Reference to Psychiatric Problems, Presented at the Conference Held at Springfield, Mo.* Washington, DC: United States Public Health Service, 1934.

Vaught, Louis Allen. *Vaught's Practical Character Reader*. Chicago: Vaught-Rocine Pub. Co,, 1907.

Wells, Samuel Roberts. *How to Read Character: A New Illustrated Hand-Book of Phrenology and Physiognomy, for Students and Examiners; With a Descriptive Chart.* New York: Fowler & Wells, 1884.

White, William A. *Foundations of Psychiatry.* Nervous and Mental Disease Monograph Series No. 32. New York and Washington: Nervous and Mental Disease Publishing Company, 1922.

White, William A. *Insanity and the Criminal Law*. New York: The Macmillan Co., 1923.

Wines, E. C., ed. *Transactions of the Fourth National Prison Congress Held in New York, June 6–9, 1876: Being the Report of the National Prison Association of the United States for the Years 1874 and 1875*. New York: Office of the Association, 1877.

Wines, E. C., ed. *Transactions of the National Congress on Penitentiary and Reformatory Discipline Held at Cincinnati, Ohio, October 12–18, 1870.* Albany: Weed, Parsons and Company, Printers, 1871.

Wines, E. C., ed. *Transactions of the Third National Prison Reform Congress Held At Saint Louis, Missouri, May 13–16, 1874: Being The Third Annual Report of the National Prison Association of the United States*. New York: Office of the Association, 1874.

Wood, Henry. *Studies in the Thought World of Practical Mind Art.* Boston, Lee and Sheppard Publishers, 1896.

"The Work of Dr. Amos O. Squire in Sing Sing Prison." *Journal of the American Institute of Criminal Law and Criminology* 9, no. 2 (Aug 1918): 275–276.

Archival Sources

City Directories, 1850–1933. Washington County Historical Society. Stillwater, MN.

Medical Notebook of Dr. Burton Jay Merrill. Washington County Historical Society. Stillwater, MN.

Meeting Minutes, Prison Reports to the MN State Board of Control, 1915–1944. Minnesota State Prison, Stillwater, MN.

Mental Health Association in New York State, Inc. records, 1879–2002. M. E. Grenander Department of Special Collections and Archives. University at Albany, the State University of New York, Albany, NY.

Merrill, Dr. Burton Jay papers. Washington County Historical Society. Stillwater, MN.

Minnesota Security Hospital records, 1911–1987. Minnesota Historical Society. Saint Paul, MN.

Minnesota State Prison records. Minnesota Historical Society. Saint Paul, MN.

Morris, Prof. George letters. Washington County Historical Society. Stillwater, MN.

Osbourne Family papers, 1786-1968. Syracuse University Library. Syracuse, NY.

Physical Inspection Notes, 1920–1940. Minnesota State Prison, Stillwater, MN.

Prison Photograph Collection. Washington County Historical Society. Stillwater, MN.

Saint Peter State Hospital records. Minnesota Historical Society. Saint Paul, MN.

State Prison at Stillwater correspondence. Washington County Historical Society. Stillwater, MN.

Warden's Correspondence, 1915–1923, 1927–1935, 1941–1958. Minnesota State Prison, Stillwater, MN.

Warden's Notebooks, 1860–1874, 1888–1889, 1890–1912. Washington County Historical Society. Stillwater, MN.

Washington Co. Medical Society records. Washington County Historical Society. Stillwater, MN.

Work Records of Prison Staff, 1922–1955. Minnesota State Prison, Stillwater, MN.

Appendix A. Detailed disease classification by researcher-imposed grouping.[1]

Infectious Disease
- Typhoid
- Typhus
- Malaria
- Smallpox
- Measles
- Scarlet Fever
- Whooping Cough
- Diphtheria
- Cholera
- Dysentery
- Erysipelas
- Chicken Pox
- Mumps
- Rheumatic Fever
- Fevers
- Meningitis
- Tuberculosis
- Other

Chronic Disease
- Fevers (not elsewhere classified)
- Tumors
- Rheumatism
- Scurvy
- Diabetes
- Anemia
- Alcoholism

Venereal Disease
- Gonorrhea
- Syphilis
- Other

Cancer
- Cancer of Stomach/Liver/Digestive
- Cancer of Skin
- Cancer (not elsewhere classified)

Diseases of the Nervous System
- Headache
- Vertigo
- Eye/Ear Disease
- Cerebral Hemorrhage
- Paralysis
- Convulsions
- Chorea
- Epilepsy
- Neuralgia/Neuritis
- Other

Diseases of the Circulatory System
- Pericarditis
- Heart Disease
- Other Disorders of the Heart
- Disease of Arteries
- Disease of Veins
- Hemorrhages

[1] Composed from the disease classifications systems of the US Census, the IPUMS-USA project, and Douglas Anderton. See: U.S. Census Bureau, *Manual of International Classification of Causes of Death* (Washington, D.C.: U.S. Department of Commerce and Labor, 1902); Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine-readable database]. Minneapolis: University of Minnesota, 2010; Douglas L. Anderton and Susan I. Hautaniemi, "Grammars of death: An analysis of nineteenth-century literal causes of dead from the age of miasmas to germ theory," *Social Science History* 28 (2004): 111–143; Jeffrey K. Beemer, Douglas L. Anderton, and Susan I. Hautaniemi "Sewers in the city: A case study of individual-level mortality and public health initiatives in Northampton, Massachusetts, at the turn of the century," *Journal of the History of Medicine and Allied Sciences* 60 (2005): 42–72.

Diseases of the Digestive System
- Throat
- Ulcers
- Dyspepsia
- Other Stomach
- Diarrhea, Enteritis
- Colic
- Hernias, Obstruction
- Other Intestinal
- Atrophy of Liver
- Other Liver
- Disease of Spleen

Gastrointestinal Disease
- Chronic Nephritis
- Kidney
- Urinary Tract Calculi
- Disease of Bladder
- Disease of Urethra
- Inflammation, Prostate Gland

Diseases of the Skin and Adnexa
- Furuncle
- Abscess
- Hemorrhoids
- Other Skin Disease

Diseases of the Respiratory System
- Influenza
- Acute Bronchitis
- Chronic Bronchitis
- Pneumonia
- Pleurisy
- Pulmonary Congestion
- Asthma
- Cold
- Other Respiratory

Diseases of the Skeletal System
- Leg, Ankle, Foot
- Hip
- Back or Spine
- Dental
- Necrosis

General Debility
- Chronic Illness (not elsewhere classified)
- Poisoned

Unknown Illness
- Malingering
- Feigned Illness
- Other/Miscellaneous

Physical Injury
- Maimed
- Burns
- Gunshot Wounds
- Injury, Ribcage
- Injury to Back, Spine
- Amputation/Missing Limbs
- Fractures
- Injury to Hip
- Injury to Arm, Hand
- Accidents
- Injury to Leg, Ankle

Appendix B. Chart of relevant staff at Minnesota State Prison, 1860-1920.

Year	Warden	Physician (MD)	Hospital Steward
1860	John S. Proctor	HF Noyes	none
1861	JS Proctor	HF Noyes	none
1865	JS Proctor	JK Reiner	none
1866	JS Proctor	JK Reiner	none
1867	JS Proctor	JK Reiner	none
1868	Joshua L. Taylor	JK Reiner	none
1869	JL Taylor	JK Reiner	none
1870	Henry A. Jackman	JK Reiner	none
1871	HA Jackman	JK Reiner	none
1872	HA Jackman	JK Reiner	none
1873	HA Jackman	JK Reiner	none
1874	HA Jackman	George M Lambert	none
1875	John A. Reed	George M Lambert	none
1876	JA Reed	Willis H Pratt[2]	none
1877	JA Reed	WH Pratt	none

[2] Willis H. Pratt was born in Hudson, NY, but spent most of his childhood in Michigan. He attended the University of Michigan medical school, earning a degree in medicine in 1869. A year late, Pratt married Eliza J. Stephens. The Pratts remained in Michigan until 1871, at which time the Pratts moved to Stillwater, MN and Pratt opened a small practice in the town. See: Marquis, Albert Nelson, Editor. *The Book of Minnesotans: A Biographical Dictionary of Leading Living Men in the State of Minnesota*. Chicago: A.N. Marquis & Co, 1907: p. 412; Pratt, WH. "The Health of the City" in *Stillwater Gazette*, Aug 22, 1904.

Year	Warden	Physician (MD)	Hospital Steward
1878	JA Reed	WH Pratt	none
1879	JA Reed	WH Pratt	none
1880	JA Reed	WH Pratt	none
1881	JA Reed	WH Pratt	none
1882	JA Reed	WH Pratt	none
1883	JA Reed	WH Pratt	none
1884	JA Reed	WH Pratt	Frank H Hall
1885	JA Reed	WH Pratt	Frank H Hall
1886	JA Reed	WH Pratt	Frank H Hall
1887	Halvur G Stordock	WH Pratt	Frank H Hall
1888	HG Stordock	WH Pratt	Frank H Hall
1889	John J. Randal	Burton Jay Merrill[3]	CR Keyes
1890	JJ Randal	BJ Merrill	CR Keyes
1891	Albert Gavin	BJ Merrill	CR Keyes
1892	Henry Wolfer	BJ Merrill	CR Keyes
1893	H Wolfer	BJ Merrill	E. Sydney Boleyn, MD
1894	H Wolfer	BJ Merrill	E. Sydney Boleyn, MD

[3] Burton Jay Merrill was born in Palmayra, IA in 1856, the son of Philo and Sophia (Woodward) Merrill. He graduated from Iowa College in Grinnel, IA and continued to study medicine at Bellevue Hospital Medical College, where he graduated with his medical degree in 1881. The same year, Pratt married Cornelia E. Merrill of Hudson, WI and practiced medicine in Hudson, WI for one year before starting a practice in Stillwater, MN in 1882. See: Marquis, Albert Nelson, Editor. *The Book of Minnesotans: A Biographical Dictionary of Leading Living Men in the State of Minnesota*. Chicago: A.N. Marquis & Co, 1907: p. 349-350.

Year	Warden	Physician (MD)	Hospital Steward
1895	H Wolfer	BJ Merrill[4]	Daniel G. Beebe, MD
1896	H Wolfer	BJ Merrill[5]	Daniel G. Beebe, MD
1897	H Wolfer	BJ Merrill	M.E. Withrow, MD
1898	H Wolfer	BJ Merrill	M.E. Withrow, MD
1899	H Wolfer	BJ Merrill	"Local Physician"
1900	Gen. C. McReeve	BJ Merrill	no listing
1901	H Wolfer	BJ Merrill	"Local Physician"
1902	H Wolfer	BJ Merrill	"Local Physician"
1903	H Wolfer	BJ Merrill	"Local Physician"
1904	H Wolfer	BJ Merrill	"Local Physician"
1905	H Wolfer	BJ Merrill	"Local Physician"
1906	H Wolfer	BJ Merrill	"Local Physician"
1907	H Wolfer	BJ Merrill	"Local Physician"
1908	H Wolfer	BJ Merrill	"Local Physician"
1909	H Wolfer	BJ Merrill	"Local Physician"
1910	H Wolfer	BJ Merrill	"Local Physician"

[4] Merrill mentored Gustavus Adolphus Newman, a recent graduate from the University of Minnesota Medical School, between July 1895 and 1896. Newman would later take-over the role of prison physician from Merrill in 1911. See: Notebook of Burton Jay Merrill. Washington Country Historical Society, Stillwater, MN.

[5] Merrill mentored Gustavus Adolphus Newman, a recent graduate from the University of Minnesota Medical School, between July 1895 and 1896. Newman would later take-over the role of prison physician from Merrill in 1911. See: Notebook of Burton Jay Merrill. Washington Country Historical Society, Stillwater, MN.

Year	Warden	Physician (MD)	Hospital Steward
1911	H Wolfer	GA Newman	"Local Physician"
1912	H Wolfer	GA Newman	"Local Physician"
1913	H Wolfer	GA Newman	"Local Physician"
1914	H Wolfer	GA Newman	"Local Physician"
1915	CS Reed	GA Newman	no listing
1916	CS Reed	GA Newman	no listing
1917	CS Reed	GA Newman	"Local Physician"
1918	CS Reed	GA Newman	"Local Physician"
1919	CS Reed	GA Newman	William J. Patterson, MD
1920	CS Reed	GA Newman	William J. Patterson, MD

Appendix C. Duties of the Prison Physician of the Minnesota State Prison, Stillwater, Minnesota.

Duties of the Prison Physician.[1]

The Physician shall give his entire time to the institution and have no outside practice. He shall examine and prescribe for all sick inmates, and also at such other times as the condition of the inmates may demand. He shall also visit all prisoners in the sick cells who are unable to come to sick call.

2. He shall examine every inmate on his entering the prison, and record in a book for that purpose, his name, date of entrance, date of examination, nationality and race of inmate, and his parents; his weight, statue and heredity, so far as affects his criminality or health; also the condition of his heart, lungs and other organs; the rate of pulse and respiration; the measurement of the chest and abdomen; and any existing disease, deformity or other acquired disability, and he shall immediately vaccinate him.

3. He shall keep a record of all admissions to, and discharge from the hospital, and all cases treated by him, with the name, number and the place of the inmate, and the diagnosis and treatment, with such observations as may assist in forming a perfect record of each patient.

4. He shall make a written report daily to the Warden of the attendance at the sick call in the morning, and of the disposition made of those reported sick. And also of all admissions to, and discharges from the hospital.

5. He shall, every morning and evening, carefully examine all inmates in the solitary cells, or in special restraint or punishment elsewhere, and shall make a written report to the Warden as to the condition of each. He shall be particular to report to the Warden in writing, any inmate whose health he thinks is being injured by the punishment or restraint he is being subjected to, and shall recommend such changes in such inmate's diet or otherwise as he may think necessary.

6. The Physician shall frequently, and also whenever requested by the Warden, examine all the cells of inmates, the plumbing and cell ventilators for the purpose of

---

[1] Exact list recreated from: "Duties of the Prison Physician" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p 85-87;
This list of duties was created after the prison physician became a full-time employee of the prison in 1896. Prior to his becoming a full-time employee of the prison, the part-time physician was allowed to have, and typically had, a private practice in the Stillwater, MN area. His work at the prison supplemented his income from his primary private practice. There have been few changes to the original description of duties of the full-time physician between 1865 and 1920. Any significant changes to the specific duties of the physician outside of what is described above will be noted in a footnote.

ascertaining whether they are kept in a proper state of cleanliness and ventilation and in a good sanitary condition and report their condition to the Warden and to the official who made the request.

7. He shall, whenever requested by the Warden, and also whenever he thinks proper, examine the quality of the provisions and conditions of the food provided for inmates. Whenever he shall find that any provisions are unwholesome, or that the food is insufficient, or for any reason prejudicial to their health, he shall immediately make report thereof to the Warden.

8. He shall have full control over the patients in the hospital, subject to the rules of the prison and instructions of the Warden.

9. In case an inmate claims to be unable to labor by reason of sickness or other disability, the Physician shall examine such inmate. If, in his opinion, such inmate is unable to labor, or his occupation should be changed, he shall immediately certify the fact to the Warden. Such inmate shall thereupon be released from labor or his occupation be changed or he be admitted to the hospital or elsewhere for medical treatment, as the Physician shall direct, having due regard for the safe keeping of such inmate. When he certifies that such inmate is sufficiently recovered to be able to labor, the inmate may be required to do so.

10. Whenever a prisoner is injured, whatever may have been the cause it shall be the duty of the Physician to carefully examine and dress the wound and immediately report the nature of the injury and its cause, in writing, direct to the Warden, and in his absence, do the Deputy Warden.

11. He shall, whenever requested to do so by the Warden, make a careful examination of any inmate, and make a written report of his physical and mental condition.

12. Whenever and inmate, in the opinion of the Physician, become insane, he shall certify the fact to the warden, giving his reasons therefor, and make a full statement of the mental and physical condition of the prisoner together with his opinion as to what disposition should be made of him.

13. Should he observe the death of a prisoner approaching, he shall notify the Warden or Deputy Warden in order that information may be sent to the Chaplain.

14. Whenever an inmate dies, the Physician shall record the cause of death and all circumstances connected therewith, and as full a history of the previous health of the prisoner as he may be able, and immediately report the information to the Warden.

15. When the Physician considers it necessary, or when requested by the Warden, to make a post-mortem examination of the body of the deceased inmate, he shall do so within twenty-four hours thereafter, if possible, and shall immediately make a written report of the result of his examination to the Warden as to the cause of death. He shall also call the coroner of the county whenever he may deem it proper to do so.

16. The Physician may be assigned such number of nurses as may be necessary to properly care for the sick.

17. He should see that the utmost cleanliness prevails, and shall be held responsible for the nurses and that good order and cleanliness is maintained in the hospital at all times.

18. He shall keep such books, and in such form as may be ordered by the Warden. Such books shall be at all times subject to examination by the Board of Control and by the Warden.

19. He shall report in writing to the Warden for the information of the Board of Control at its monthly meeting, the patients received into the hospital or treated in the cells or elsewhere during the preceding month, stating their respective ages, diseases, previous occupations in prison, the time they have remained in the hospital or cells, the date of commencement and termination of treatment, and number of days during which such patients, in consequence of sickness, have been relieved from labor. Also the deaths and cause thereof, transfer to Insane Asylums and such other facts with recommendations as he desires to submit.

20. At the close of each biennial period the Physician shall make a report to the Board of Control as to the sanitary conditions of the prison during the biennial period just passed, in which he shall present, in summarized form, included in his daily and monthly reports. The Physician will be responsible for all instruments and supplies in his department.

Appendix D. Duties of the Warden of the Minnesota State Prison, Stillwater, Minnesota.

Rules of Government

THE WARDEN[1]

The Warden in the performance of his duties as chief executive office of the State Prison shall be guided by the Statutes directing the management of the prison, and by such rules and orders as may from time to time, be adopted to familiarize himself with the rules governing the subordinate officers, keepers, employees and inmates, and see that they are complied with. He shall make such reports to the Board of Control, at their regular or special meetings, as the condition of the business or other interest of the institution may make necessary. Any inmate of the prison may at any time, address, sealed, a subject deemed by such inmate to effect his interest, or the interest of the institution. Any the Warden shall forward the same to the chairman or to any member of the Board to whom the letter may be addressed, and the chairman, or member of said Board after examining such letter, will confer with the Warden as to its contents, and if he deems it best to do so, he may bring such letter to the attention of the Board for its action.

The Warden shall reside at the institution, and is the general executive officer of the Board of Control. But the law also especially directs, that he shall appoint all subordinate officers and employees, It shall be the duty of the Warden in all cases to appoint such subordinate officers and employees only after a rigid examination as to their education, moral character and fitness for the care and custody of those persons who may be sentenced to imprisonment in prison, and it shall be incumbent upon him to require all applicants for position to fill out in their own handwriting and in the presence of the Warden or such authorized officer as he may direct a blank form of application, giving his name, age, whether married or single, occupation, by whom last employed, condition of eye sight, whether he has any physical ailments or not, whether he uses any intoxicating liquors in any form, post office address, where he has lived for five years, preceding his application, references, etc.

As the responsibility for the successful management of the prison rests upon the Board of Control, and as the law provides that the Warden shall appoint all officers and employees, the Board of Control hereby recommends that officer in selecting his several subordinate officers, to observe the following suggestions to those specially directed by the statute.

Political partisan interest must never be consulted. Competent and efficient officers shall not be removed to give place to those not known to have superior

[1] Exact list recreated from: "Rules of Government: The Warden" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p. 79-80;
This list describes the duties of the Warden of Minnesota State Prison in the early twentieth century. The list of duties of the Warden are defined by the Board of Control and appeared in the annual report for the first time in 1865.

qualifications and experience. Character, intelligence, special adaptability to the position to be filled, either natural or acquired, industrious inclination and habit, a desire to make institutional work a business to be followed, these are pre-essentials to applicants for appointment. Special attention should be given as to age, previous employment, references and other facts affecting their fitness for the position solicited. The Board is of the opinion that the best interest of the institution can be subserved by appointing none over forty years of age.

The Warden shall have charge of books and papers, and of the lands, buildings, furniture, apparatus, tools, stocks, provisions, and every other species of property of the State Prison. And he shall have charge of the inmates of the institution, and shall classify them under such rules and regulations as have been or may from time to time be prescribed by the Board of Control. He shall discipline, govern, instruct, employ and use his best efforts to reform them. He shall cause a register to be kept, in which shall be entered the date of admission, name, age, nativity, and nationality, with such other facts as can be ascertained of parentage, education, occupation, and early social influences affecting each individual, as aids to treatment in his reformation. It shall be his duty to recommend worthy inmates for parole.[2] He shall keep in correspondence with such as are absent under parole requiring regular monthly reports from all such parole prisoners, and he shall recommend, from time to time, that those whose reformation has been verified by perfect conduct, while under parole be discharged from further imprisonment.[3]

It shall be the duty to of the Warden to make a complete written or typewritten statement of all matters that should come before the Board for its information and consideration. He shall lay before the Board for its examination the daily journal containing infractions of the rules and regulations of the prison by officers or employees; a journal containing every complaint made by any convict of cruel or unjust treatment by any officer of the prison, the daily report journal containing infractions of the rules by convicts; the grade book, the journal containing a personal history prior to the conviction of each inmate, of all prisoners committed on the reformatory plan; the monthly report of all prisoners on parole, with all correspondence relating thereto; book containing copies of all letters of inquiry written by the Warden bearing upon the taining copies of all letters of inquire written by the Warden bearing upon the previous history and character of all prisoners who come before the Board as applicants for parole. He shall make a complete statement of all changes that have been made during the preceding month whether of officers, employees, or in the administration of affairs of the prison, giving particulars in detail, the names of all officers, guards or employees engaged or discharged in the preceding month, with statement of reason therefor.

---

[2] Parole was introduced at Minnesota State Prison in 1893.

[3] The prison physician assisted with this assessment. Ultimately it was the warden who reported an inmate's file to the parole board, though.

Appendix E. Duties of the Deputy Warden of the Minnesota State Prison, Stillwater, Minnesota.

Duties of the Deputy Warden[1]

1. The Deputy Warden is the assistant and agent of the Warden in the government and management of the inmates of the prison—most particularly in securing compliance with its rules by the subordinate officers, employers and inmates.

2. He shall be present daily at the prison from the hour of unlocking in the morning until after the inmates shall have been locked up at night, unless leave of absence has been granted by the Warden, and he shall visit the prison occasionally at night, and personally ascertain that the inmates are secure and that the officers are on duty and alert.

3. In the absence of the Warden, the Deputy shall perform the duty of that office relating to the government and management of the inmates of the prison. His orders shall be respected and obeyed by the subordinate officers, guards, employees and inmates, so far as relates to the discipline and carrying out such rules and orders of the Board of Control are not otherwise delegated.

4. Under the order of the Warden, the Deputy Warden shall have special control and direction of all officers under his own rank, and all guards and employees of the prison, and shall be responsible that every one performs his respective duties with intelligence, fidelity, and zeal. It shall also be his duty to promptly report to the Warden every neglect of duty to, impropriety, or misconduct, on the part of any officer, guard or employee.

5. The Deupty Warden shall be minute in the inspection of every person when coming on duty, especially armed guards, and other arms, and shall report to the Warden the name of any person who may come on duty under the influence of intoxicants, or without being in an appropriate uniform, or whose uniform is not in good condition; and all who are unworthy or inefficient for any cause.

6. He may grant leave of absence to any officer, or employee for a period of one day, but no longer, without consulting the Warden, except on the emergent occasions, and then only in the absence of the Warden. The Deputy Warden shall enforce obedience to the rules and regulations, and to all orders given by the Warden, and shall maintain, generally, the police and discipline of the prison with the strictest exactness. For that

[1] Exact list recreated from: "Duties of the Deputy Warden" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p. 80-83;
This list describes the duties of the Warden of Minnesota State Prison in the early twentieth century. The list of duties of the Warden are defined by the Board of Control and appeared in the annual report for the first time in 1865.

purpose he shall frequently, during the day, but at irregular intervals and without notice, visit the shops, towers, yards, guardposts, hospital, kitchen, cells and other apartments of the prison, and the different places where work is being done, and take every precaution for the security of the place and its inmates. And he shall see that the officers and guards are vigilant and attentive to their duties, and that they keep the inmates in their charge diligently employed during the hours of labor.

7. He shall not permit any book, pamphlet, or newspaper to be read by, or be in possession of, any subordinate officer, guard, foreman, or employee while on duty in or about the prison. Nor shall he permit the use of liquor or smoking on the premises by any such office, instructor, guard, or employee, while on duty.

8. When an inmate is received, the Deputy Warden shall see that he is bathed, shaved and has his hair cut, clothed in the suit of a second grade inmate, and the duly presented to the Physician for examination, after which he shall measure him according to the Bertillon system, and also carefully examine into his past history and character, reporting same on blanks furnished for that purpose after which he shall assign him to work under the direction of the Warden. He shall, at short intervals, but irregularly examine the gates, locks, doors, levers and gratings in and about the prison, and see that they are in a good safe condition.

9. He shall exercise due vigilance to see that there is no unnecessary waste or loess of the property of the prison, and that there is the strictest economy in the consumption and use of the supplies. Also that thorough neatness, cleanliness and good order are maintained throughout all the buildings and the grounds.

10. He shall make himself acquired with the social habits and conduct of every subordinate officer, guard or employee of the prison, and particularly whether, when of duty, such officer, guard or employee is a frequenter of saloons, or other houses of similar resort, or associates with idle or loose characters, and report his information to the Warden.

11. He shall see that no material is allowed to be placed near the enclosing walls, and that nothing is accessible to inmates which might facilitate escape. He shall especially see that all ladders are properly secured.

12. As all business must be first directed through the office of the institution, he shall have a vigilant eye over every person who may have business with the prison, yards or workshops. And also see that nothing which has not been authorized by inspection in the office is carried in or out for inmates or others, and that no communication is held by such person with any inmate, except by authority granted, and in the presence of an officer.

13. He shall, every night, before relieving the officers and guards from duty, verify, by actual count of inmates to be made by subordinates, the written daily count report furnished him from the office.

14. As the prison reformatory law affords to inmates the privilege of earning diminution of imprisonment from maximum sentence, effects their rad standing, and in consequence their chances for parole, it will be incumbent upon all authorities of the prison to give the strictest attention to the conduct of each, that no injustice be done to any inmate or to the state. And especially it shall be the duty of the Deputy Warden to satisfy himself as to the behavior of each inmate, and his industry, alacrity and zeal in the execution of his work, so that he may be able to advise with the Warden as to the merits and proper standing of each. For this purpose he shall, when making his rounds, frequently communicate with officers, guards and employees.

15. All breaches of discipline, or other offenses by an inmate, must be immediately reported in writing by the office in charge to the Deputy Warden, who shall, at the earliest opportunity, make full inquiry into the facts. And if he cannot easily excuse or correct the offender without the infliction of a penalty, he will make a full report to the Warden, at the earliest practical moment, and inflict such punishment as may be necessary under his direction.

16. The Deputy Warden shall select from the trust inmates a sufficient number to compose a well regulated fire department and assign them to their respective duties and stations in conjunction an in harmony with the Chief Engineer. Frequent tests of the fire apparatus shall be made and frequent false alarms given and runs made to test the efficiency of the department.

17. He shall take careful invoice of all personal property brought in by prisoners, and deposit it with the Chief Clerk for safe keeping. It shall also be his duty to store and preserve in as good condition as possible the clothing worn in by a prisoner when requested to do so by said prisoner.

18. The Deputy Warden will assign inmates to the several employments and make details of inmates to act as runners, messengers, or distributors of material in shops or elsewhere, and will decide how far such inmates may converse with other inmates, and give them such permission if any is necessary, though the officer in charge. He will, each day, make a written report to the Warden, giving the number of inmates on the previous day and how many were employed.

Appendix F. Duties of the Prison Chaplains of the Minnesota State Prison, Stillwater, Minnesota.

Duties of the Chaplains.[1]

1. The Chaplains of the prison, Catholic and Protestant, shall conduct religious services i the prison chapel each alternate Sunday, under such rules and regulations as the Warden may prescribe, which service shall not be sectarian in character, but shall recognize the Christian faith as a basis of religious teaching.

2. They shall not have intercourse with the prisoners in the shops or while they are at work or hold communication with them except as may be necessary or proper in imparting to them such secular and religious instructions as they are required by law and the prison regulations.

3. They shall visit the sick in the hospital, and administer to their spiritual wants. They shall have free access to every part of the prison and every facility to impart moral and religious instructions; but they shall not furnish the prisoner with any information or intelligence in relation to outside matters except by permission of the Warden.

4. Sectarian religious doctrines shall not be taught nor shall any attempt be made to proselyte a prisoner. If any prisoner desires communication with the minister or an instructor in his particular faith, on proper application to the Warden, it shall be allowed, under and in conformity with the law and the general regulations of the prison. But such minister or instructor on such occasions must conform to the rules and regulations for the government of Chaplains. Any infringement or departure from the rules will debar him from future intercourse with the prisoners.

5. The Chaplains shall assist the Warden in the selection of new books for the library and aid him in making proper distribution of moral and religious books to inmates.

6. The shall make biennial reports to the Board of Control at the end of each biennial report, relative to the religious and moral conduct of the prisoners, the number of services they have performed, the result of their labors as indicated by moral and religious movements, together with any other facts they may deem proper to report.

---

[1] Exact list recreated from: "Duties of the Prison Chaplains" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p. 87;
This list describes the duties of the prison chaplains of Minnesota State Prison in the early twentieth century. The duties of the chaplains first appeared in the annual reports of the state prison in 1865. At that time, the duties only referred to the one, Protestant chaplain of the prison. The prison hired a Catholic Chaplain in 1881. At that time, the duties list made reference to this new member, but the duties themselves did not change. Any changes in specific duties of the chaplain across time are noted in footnotes.

Appendix G. Duties of the Prison Matron of the Minnesota State Prison, Stillwater, Minnesota.

Duties of the Matron.[1]

1. The Matron and her Assistant shall be subject to the direction of the Warden and in his absence, the Deputy Warden, in the performance of all their duties. The head matron shall have general charge of the female prison and the prisoners and conform to the general rules and regulations governing the prison.

2. The Assistant Matron shall assist the Matron in all her duties in the absence of the head Matron, she shall have full charge as above provided. She shall also act as a forelady over any work carried on in the female department under the direction of the Warden.

3. The Matron shall not introduce any change in the nature of the employment of the prisoners without the permission of the Warden. She shall put in all of her time during work hours superintending the work carried on and looking after the discipline and good order of the female department.

4. She shall see that each prisoner under her charge is furnished with such food, clothing and such other articles as the prison shall prescribe, and shall so regulate the work of the inmates as to cause the least possible friction and promote as much as possible harmony and good order.

5. She shall see that good discipline is observed by all the inmates and that all of them faithfully perform the work required of them.

6. When a new prisoner is received, it shall be the duty of the Matron to see that she is thoroughly bathed, dressed in prison clothing and examined by the physician. Every article which the prisoner brings with her shall be taken from her and turned over the property officer having charge of such effects and taking his receipt therefor. Her responsibility for the safe-keeping of such articles is released as soon as she obtains such receipt.

---

[1] Exact list recreated from: "Duties of the Matron" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p. 89-90;
This list describes the duties of the prison matron of Minnesota State Prison in the early twentieth century. The list of duties of the matron first appeared in the annual reports in 1870. A matron was a staff member at the prison since 1875. At no time between 1880 and 1920 has the female population of the Minnesota State Prison exceeded 5% of the total population. The female population did increase steadily through the twentieth century and a separate facility to contain female offenders in Minnesota was eventually constructed in Shakopee, MN in 1986.

7. She shall attend the sick and see that they are properly cared for. She will be required to promptly report any sickness to the physician. Any sudden cases occurring either during the day or night shall also be reported to the Warden, or in his absence to the Deputy Warden, and if during the night time to the Captain of the night watch.

8. She shall not absent herself from the prison during her hours of duty without permission of the Warden, or in his absence, the Deputy Warden.

9. She should reside at the prison in apartments, furnished her by the Warden and shall, on the first of each month, furnish a written report to the Warden of all work done in her department during the preceding month and the general condition thereof.

10. She shall accompany the Physician when he visits the female department and report to him any prisoner requiring his attention, whether the prisoner requests it or no, but she shall always call the Physician whenever requested to do so by the Prisoner.

Appendix H. Excerpts from general rules for inmates, as depicted in the inmate handbook and re-printed in the annual reports of the prison.

General Rules[1]

For Governance of Inmates

Your attention is directed to the following rules. Only by observing and obeying them can you make a good record as an inmate and become eligible for parole and the diminution of your sentence which the law allows:

1. Your first duty is strict obedience to the rules and regulations and any orders of the officer under whose charge you may be placed.

2. You must observe strict silence in all departments of the Prison and while marching through the yard.

3. You must not speak to, give or receive visitors, anything except by permission of the Warden or Deputy Warden. Gazing at visitors or strangers passing through the Prison is strictly forbidden.

4. You are expected to apply yourself diligently to whatever labor you are assigned and after reasonable teaching to perform the same amount of work as would be required of you as a citizen.

5. At every signal to fall in for marching, take your place in line promptly. March with military step, attend to and promptly obey the orders of your officer.

6. You will be required to keep your person clean and your clothing tidy and in good order. You must not make any alterations in your clothing or cut your shoes. If they do not fit or need repairs report the fact to your officer. You must not carry knives, tools of any kind, pencil, paper or any material from your shop to your cell without permission in writing from the Warden or Deputy Warden. Finding any of these things in your possession will be considered proof that you have violated this rule. Tinkering or writing notes to other inmates or carrying notes from one inmate to another is strictly forbidden.

7. You are not allowed to have any money on your person or in your possession, neither are you permitted to trade or purchase any article whatever. All your business must be done through the Warden.

---

[1] Exact from: Inmate Handbook. Stillwater, MN: The Mirror, 1915; "General Rules" in *Nineteenth Biennial Report of the Minnesota State Prison (1915-1916).* Stillwater, MN: The Mirror, 1917, p. 101-108.

8. You must approach an officer in a respectful manner. Always salute him before speaking. You must confine your conversation with him strictly to the business in hand. You must not address an officer on matters outside of the Prison. Insolence in any form to an officer, foreman, or even to a fellow inmate will not be tolerated.

9. On entering the cell house, office of the Board of Control, Warden, or Deputy Warden, you must uncover unless your duties are such that you have special permission to remain covered.

Privileges

You are not compelled to attend religious services, but you are specially request to do so believing that the moral support of religious instruction is necessary to all.

You are required to bathe once a week, and oftener if considered necessary by the Prison Physician unless excused by him, the Warden or Deputy Warden.

On entering the Prison you will receive (3) tickets entitling you to the following privileges as long as you obey strictly all the rules of the Prison.
First—One ration of tobacco each week.
Second—Permission to write under grade rules.
Third—Permission to see friends once in four weeks.

Newspapers. You are permitted to receive such weekly papers as the Warden may approve. No daily papers or sensational publications of any descriptions will be permitted.

Extra Letter. Written permission must be obtained from the Warden or Deputy Warden in case it becomes necessary to write special letters.

Mail Matter. Letters and papers of every description must be examined at the office under the direction of the Warden before being mailed or delivered.

Shop Rules

1. On entering the shop change to your working clothes and go to work promptly. If you have any cause for complaint, whether from keeper, foreman or others, you will be allowed to send application for an interview through your officer at any time, to the Board of Control, Warden or Deputy Warden.

2. Communication between inmates is strictly prohibited and will not be allowed at any time except by special permission of the officer in charge and then only when absolutely necessary.

3. In talking with you foreman you are required to confine yourself strictly to your shop duties. You will not be allowed to talk when him upon matters pertaining to outside news.

4. You will be required to approach your officer in a respectful manner. Always salute him before addressing him and make your wants known as briefly as possible.

5. You will be required to give your individual attention to your work. Gazing about, at visitors passing through the shop or at other inmates, will not be allowed. You must respectfully listen to and faithfully carry out all instructions given you by your foreman pertaining to your work.

6. You will not be allowed to leave your place of work except by permission of the officer in charge.

7. You will not be allowed to brush against a fellow inmate in passing, to get in each other's way or otherwise trespass upon the rights of each other so as to provoke ill feeling.

8. Careless or wilful injury of your work or tools will be promptly reported.

9. You must always salute an officer on entering or retiring from your shop. You will not be permitted to leave shop or place of work under any circumstances, without first obtaining special permission of the officer in charge.

10. If you are sick and unable to work report the fact to your officer and act as he may direct. If you desire to see the Physician give your name to your officer immediately after entering the shop in the morning.

11. All trading or bartering of whatsoever kind between inmates or between citizens and inmates, is strictly prohibited. You will not be allowed to give or receive any present or gift from a foreman or citizen under any condition.

12. If it becomes necessary to use a lead pencil about your work, apply to your officer who will supply you. Pencil must invariably be returned to the officer every evening. You will not be allowed to cut off or appropriate any part of the pencil.

Dining Hall Rules

1. On entering the dining hall take your seat promptly—position erect—arms folded, with eyes to the front until the signal is given to commence eating.

2. Strict silence must be observed during the meal. Staring at visitors, talking and laughing, fooling or gazing about the room is strictly forbidden.

3. Eating or drinking before or after the gong sounds, using vinegar in your drinking water, or putting mean on the table, is prohibited.

4. Should you desire additional food make your wants known to the officer. Wasting food in any form will not be tolerated. You must not ask for or allow waiter to place on your place more food than you can eat.

5. After finishing your meal place knife, fork and spoon on right side of plate. Sit erect with arms folded. When signal is given to rise, drop hands at your side. At the second signal of the gong march out and to your respective place in line in a prompt and quiet manner.

6. In passing to and from the dining hall you must not gaze into cells or loiter against the rules to carry out of the dining hall furnishings or to carry food to or from the dining hall at any time except on Sunday and holidays when you will be allowed to carry lunch to your cell for the evening meal.

Cellhouse Rules

1. At the sound of the morning gong you must turn out promptly, wash, dress, make up your bed neatly as instructed, and be in readiness to march out. At the signal, open the door, step out, form in line as directed, and stand erect until ordered to march.

2. Upon entering the cellhouse in the evening you will remain standing with your hand on the door until the double count is made, of which you will be notified by the sound of gong.

3. You will be required to keep your library books and cell furniture clean and in good order. Marking the walls, spitting on the cell floor, corridor or flags will not be allowed. You will be permitted two library books each week. When change of book is desired place library slip on cell door evening before issue.

4. You will be required to place your writing and tobacco tickets on cell door immediately after breakfast Sunday mornings (in plain view) otherwise these privileges

will be withheld. You must return all writing material given to your whether used or not. Failing to do this will deprive you of your writing privileges.

5. You must not keep food in your cell, except evening lunch, which you are allowed to bring from dining room on Sundays and holidays. Immediately after supper you will be required to place any bread, left on the crossbar of your cell door to be gathered up by the waiter. You must not throw any food in your lavatory.

6. You are required to clean your cup and wash basin and keep them bright and clean at all times. You must make up your bed neatly and carefully according to instructions.

7. Strict silence must be observed in your cell at all times. Talking, laughing, reading aloud, shuffling of feet, drawing chair across cell floor or talking from cell to cell is strictly prohibited. You must not tamper with your electric light. If it does not burn properly report the fact to the officer on duty.

8. You are entitled to the following cell furniture: One Bible, one cup, one mirror, one face towel, one dish towel, one piece of soap, one comb, blankets, sheets, pillow-cases, mattress, bed and springs, one wooden chair, one electric light, one library catalogue and all the library and school books required.

9. All inmates attending school will be required to give close attention to their studies in the schoolroom and in their cells through the entire term of eight months commencing September 15th and ending May 15th of each year, unless excused by the Warden or Physician.

10. At the sound of the gong three times at 9 p.m. you must address quietly and immediately retire. If you have occasion to call the night officer, do so while he is making his rounds.

Chapel Rules

1. On entering the chapel you will march erect with arms by your side keeping in step with the music.

2. You will promptly take your seat, as designated by the officer in charge, and sit with arms folded during chapel service.

3. The signal for rising and being seated will be the south of the Deputy Warden's gavel. When the signal is given you will rise promptly and remain standing until notified to be seated. You will be allowed to drop your arms to your side while standing.

4. Strict attention must be given to the service. You must not gaze about the room at visitors or at fellow inmates, but must sit erect in your seat facing the speaker.

5. Reading, spitting on the floor, shuffling of the feet or any other unnecessary noise is strictly forbidden.

6. Should you be taken sick during service or if it becomes necessary for you to retire, raise you right hand to the officer in charge who will excuse you if necessary.

7. After service you will sit erect with arms folded giving strict attention to your officer until he gives the signal to rise when you will be required to rise promptly and march out of the chapel as directed, keeping time with the music.

8. In marching to and from the chapel you will be required to keep in close order with face to the front and in as quiet and orderly a manner as possible.

Any willful violation of these rules will be considered a serious breach of discipline and shall be promptly reported, and the violator punished if necessary to enforce compliance.

Grading

The Board of Control by virtue of the authority and power conferred upon them by Section 5 of an act of the Minnesota Legislature, entitled "An Act to regulate the sentencing of prisoners convicted of felony and their subsequent release on parole," hereby establish three (3) grades of inmates to be known and designated as the First, Second and Third grades, together with a system of marks to be governed by the following rules and regulations, which shall be in force and have effect from and after the official notification of the passage of said Act as certified by the Secretary of State under date of April 5th, 1893.

All prisoners on their arrival shall be entered in the Second Grade, they may earn nine credit marks each month and shall be marked on conduct, work and mental advancement. Promotion from Second to First Grade shall be conditioned upon the earning of fifty (50) out of the possible fifty-four (54) credit marks, within six (6) consecutive months. The loss of more than two (2) marks in any one month, shall cause the inmate so offending, to be reduced to the next lower grade. By a clear record of one (1) month, and the earning of nine (9) credit marks, shall entitle the inmate to be advanced to the next upper grade.

Prisoners may lose their grade:

First—By such violations of prison rules as shall necessarily subject them to solitary confinement.

Second—For disorderly conduct.

Third—For habitual laziness, untidiness or negligence.

First Grade. First Grade men shall be dressed in gray uniforms in winter and khaki uniforms in summer, the grades in both cases being designated by a chevron, and be entitled to following privileges: To write one letter each week; receive visits from friends once in four weeks; to receive such letters and weekly papers as the Warden may approve and from time to time such other and additional privileges and immunities, not here-in enumerated, as may be considered to concede, as a special reward for meritorious conduct, having at all times in view the best interests of discipline and good order.

Second Grade. Second Grade men shall be dressed in a plain gray suit in winter and a plain khaki suit in summer, and be entitled to the same privileges as first grade men, except that they may write only one letter each two weeks.

Third Grade. Third Grade men shall be dressed in striped clothing; they shall be allowed to have in their respective cells, a Bible, library catalogue and one good selected library book each week. All Third Grade inmates shall be deprived of privileges granted first and second grade men, except to write letters of importance as granted by Warden.

The Warden shall submit to the Board of Control each month, at its regular meeting, a report in writing, showing the grade changes for the month, giving the names of all inmates with the dates upon which they were degraded or promoted in their respective grades, and such other information as may be considered necessary to give the Board a more perfect knowledge of the discipline and general management of the Prison.

Library Rules

In ordering books the following directions must be carefully adhered to:

Write plainly upon your library slip your name and cell number. Underneath place the number of fifteen or twenty books you prefer to read. Always take your library book with you when moving from one cell to another. Bear in mind that all books are charged to you and that you will be held strictly responsible for their preservation and safe return. The catalogue and all books charged to you must be accounted for on the day of your parole or discharge or in your cell except those that have been regularly charged up and come to you though the regular channels. If you find a stray book in your cell you must turn it over to the Librarian at once. Failing to do this, in event of finding a stray library book in your cell will be the means of depriving you of all library privileges.

You are accorded the utmost liberty in the selection of reading matter, but it is hoped and wil be expected by management that the library record will show that you have exercised the diligence and regard for your own best interests in the selection of books. The Warden, Chaplains, teachers or other officers will gladly advise you concerning the selection of proper reading matter.

All library books, excepting books of reference, may be retained two weeks. Books of reference may be held but one day.

Rules for Exchanging Papers

Any inmate wishing to exchange papers or periodicals with other inmates may do so by observing the following rules:

Mark the numbers of the cells, to which you wish to send the paper or periodical, plainly on the margin thereof and drop it in the exchange box at the foot of the stairs as you go out in the morning.

After reading papers sent to you, erase your number and place papers in the exchange box the following morning, but do not add any numbers to the list nor erase any but your own.

Weekly and semi-weekly publications circulate ten days from the date of their issue; montly publication, circulate during the month of their issue.

Writing on, drawing pictures on or in any way of defacing exchanges is forbidden. Papers must be kept as clean as possible.

Restoration of Citizenship

An inmate who shall pass the entire period of his imprisonment without a violation of the rules and discipline, except such as the Warden or Board of Control shall excuse, shall upon his discharge from the Prison be restored to the rights and privileges forfeited by his conviction, and shall reciebe from the Governor a certificate under the great seal of the State as evidence of such restoriation, to be issued upon presentation to the Governor a certificate of such conduct, which shall be furnished to such inmate by the Warden.

List of Offenses

Altering Clothing
Bed not properly made
Clothing not in proper order
Communicating by signs
Defacing property
Dilatory
Dirty cell or furnishings
Disobedience
Disturbance in Cell House
Fighting
Hands in Pocket
Hands or face not clean
Hair not combed
Impertinence of visitors
Insolence to officers
Insolence to foremen
Insolence to fellow inmates
Inattentive to line
Inattentive at work
Inattentive in school
Laughing or fooling
Loud Talk in cell
Loud reading in cell
Malicious mischief
Not out of bed promptly
Not at door for count
Not wearing outside shirt
Not promptly out of cell when brake is drawn
Out of place in shop or line
Profanity
Quarreling
Shirking
Spitting on floor
Staring at visitors
Stealing
Trading
Talking in chapel
Talking in line
Talking in school
Talking at work
Talking from Cell to Cell
Talking in corridor
Throwing away food

Appendix I. Superintendents of St. Peter State Hospital, 1866-1920.

Name	Years as Superintendent
Samuel E. Shants	1866 to 1868 (died)
Cyrus K. Bartlett	1868 to 1893
Harry Tomlinson	1893 to 1912
Robert M. Phelps	1912-1920