



# The Politics of Public Health: Medical Inspection and School Nursing in Vermont, 1910–1923

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By MARILYN S. BLACKWELL

**I**n November 1916 the school nurse in Springfield, Vermont, alerted nursing supervisor Anna L. Davis of the Brattleboro Mutual Aid Association about an outbreak of diphtheria in local schools. Five “carriers” had been discovered and reported to the state board of health, whose director promptly ordered the local health officer to quarantine the families involved. “Here is where the trouble began,” Davis concluded. Health officer B. A. Chapman delegated the quarantine procedure to the school nurse, instructing her to send the “carriers” to the “school house for cultures to be taken.” Outraged at his lack of concern about contagion, Davis fumed about families who either failed to comply or sent their children to the school building, where they were “hanging about all morning.” Moreover, Chapman, who should have known that the nurse lacked authority to quarantine, insisted that he “hadn’t time to attend to these cases.” Yet, she noted, “The reason he was appointed health officer was the fact that he had almost no practice.” Davis notified an official from the state board of health, who “put the carriers under strict quarantine and read the law to our local officer.” With confidence that they would “stamp out the disease,” Davis and the school nurse began checking school absentees and watching “the Polish

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families that will not report cases.” Extending her supervision, she urged local doctors to “agree on a prescription for Pink eye,” while the school nurse prodded the state officer to investigate a tenement with a broken sewage system that Chapman had ignored. Recognizing the benefits of the state’s “authoritative backing,” Davis arranged to report her findings directly to state officials in the future.<sup>1</sup>

Anna Davis’s crusade as a public health worker in the 1910s ensnared her in the struggle between state regulators and local health and education officials in Vermont. Since its establishment in 1886, the Vermont State Board of Health had gradually expanded its visibility as its leaders sought to bring new practices in sanitation and disease control to Vermont communities, but relations between state officials and local health officers and selectmen were strained at best. State health regulations held the potential to increase local taxes and reduce local control over community affairs. The campaign to persuade Vermont lawmakers of dangers to the public health had succeeded when it paralleled other areas of incipient state authority or provided financial benefits to ensure cooperation from small towns. Dairymen seeking to protect their products, for example, reluctantly submitted to quarantining and testing for bovine tuberculosis as long as the state reimbursed them for diseased animals.<sup>2</sup> The movement to consolidate and standardize neighborhood schools eventually resulted in regulation of the condition of public school buildings, but only after Vermont’s Republican and small-town-dominated legislature had eased local burdens with a statewide school tax in 1890. These economic incentives alleviated rural poverty while expanding state supervision.<sup>3</sup> Improved curriculum and facilities in return for state aid seemed a fair bargain, but state supervision over the health of school children was another matter.

By the 1910s members of the state health board hoped to mandate medical inspection of school children as a disease control measure. The issue not only raised the question of state versus local supervision over contagious disease, but also threatened to impose the authority of health experts over both teachers and parents to ensure the well-being of children. Just as children became the focus of both school and social welfare reformers, who believed expansion of state supervision would standardize educational opportunity and help alleviate poverty, public health advocates began experimenting with disease prevention methods to stem epidemics and reduce infant mortality. As one of several measures to manage contagious disease, medical inspection in urban school districts had proved beneficial in uncovering physical problems of children and preventing ill health through early detection. The movement signaled an expansion of government responsibility for children.<sup>4</sup> If

Vermont lawmakers could muster the resources and the political will to ameliorate rural poverty through educational improvements, could they extend those efforts through public health initiatives? Health reformers, school directors, teachers, health officers, doctors, and parents all held a stake in the outcome. As a representative of the new breed of experts seeking to improve rural life, Anna Davis entered this contested terrain as she began supervising the health of Vermont school children.

This article examines the struggle over medical inspection in Vermont as a case study in the development of public health during the Progressive period. In contrast to the experience of northeastern cities, where public health nurses ensured the success of medical inspection in schools, the Vermont story provides an example of the limitations of public health provision.<sup>5</sup> The issue reveals how new professionals—doctors, nurses, educators, social welfare reformers—and politically active women attempted to influence Vermont’s politics of local control. Disagreement among advocates about who should supervise and implement a state-funded system limited their effectiveness in designing the program and securing adequate funding and personnel. As a result, medical inspection succumbed to the rising opposition of private physicians, who tapped local fears about big government in an effort to maintain authority over health care services. Rather than preventing ill health and alleviating rural poverty, this experiment in public health appeared to confirm the inadequacy of state supervision and resulted in a disparity between children’s health services in rural areas and larger towns.

#### THE EXPANDING AUTHORITY OF THE VERMONT STATE BOARD OF HEALTH

Despite continual challenges to its authority, by 1915 the Vermont State Board of Health had transformed its role from educational and advisory to regulatory. That year the state ranked ninth among forty-eight states on a set of “new public health” standards established by the American Medical Association.<sup>6</sup> The achievement was substantial given the state’s lackadaisical effort in public health during the heyday of urban sanitary reform in the late nineteenth century.<sup>7</sup> Vermont lawmakers had left responsibility for public health solely in the hands of local selectmen, who acted as a local health board to regulate public nuisances, quarantine smallpox victims, and provide medical care for the poor, all of which were limited by a dearth of funds and the local biases that typically afflicted town government. Little changed in 1886 when the threat of a statewide smallpox epidemic and the tireless efforts of physician Henry D. Holton resulted in the creation of the three-member



*Dr. Henry D. Holton  
of Brattleboro.  
The Vermonter  
22 (1917), 80.*

state health board, whose powers were largely advisory. In 1892, when the state board gained the power to appoint local health officers, selectmen continued to submit nominees and retained control over disease prevention in each town. This divided authority resulted in continual tension between state and local officials, for it was unclear whether health officers could act on their own or needed approval of the selectmen.<sup>8</sup> The real boost to state authority came in 1898 when Holton helped establish the Laboratory of Hygiene, which eventually gained support from state legislators. In 1900 the health board attained authority to test “water supplies, milk, and all food products” and examine “cases and suspected cases of diphtheria, typhoid fever, tuberculosis, malaria,” and other contagious disease.<sup>9</sup> With science on their side, Vermont’s health reformers set out to clean up the state and prevent the spread of contagious disease.

Physicians Henry D. Holton of Brattleboro and Charles S. Caverly of Rutland led the effort to bring the “new public health” to Vermont communities. As adherents of preventive medicine, they educated members of the Vermont Medical Society and local health officers about germ

theory, which had transformed the national public health movement.<sup>10</sup> Using their scientific knowledge of bacterial infection, they extended the authority of the board of health and carved out an important role for physicians in the state. Holton, who had persevered for fourteen years in the creation of the state board, brought his experience as president of the American Public Health Association in 1901 and his contacts with members of state and national medical societies to his crusade in Vermont. Born in Saxtons River in 1838 and graduated from New York University, Holton practiced in Brattleboro but spent much of his energy as a public servant. He became a member of the Vermont State Board of Health in 1896 and served as executive secretary from 1900 to 1912.<sup>11</sup> In this role and until his death in 1917, Holton, whose boundless zeal and optimism in the face of contamination and disease were legendary, condemned deficient public water supplies and sewage systems. In the face of considerable resistance, he intensified his scrutiny of public buildings and intervened in local epidemics, to the consternation of civic leaders. In 1908, for example, frustrated by Holton's quarantine procedures during a smallpox epidemic, the editor of the *Brattleboro Reformer* repeated claims voiced in the Burlington press that the doctor had recently "yanked Burlington by the tail" over water regulations and was "holding up the entire state by the tail to keep it out of the bog." Rarely deterred by this sort of criticism, Holton even described himself as an "outrageous sort of a man" who would "prosecute" health officers "for not attending to [their] duty." With the support of the Vermont Supreme Court, which affirmed the board's authority to "protect the public against disease," Holton expanded his crusade.<sup>12</sup>

Like others in the public health movement, both Holton and Caverly increasingly focused on the "carriers" of disease as they began to understand the dynamics of contamination. Caverly, who served as president of the state board from 1891 until his death in 1918, remained a step removed from local health problems but deeply involved in the development of disease control methods. With a career as impressive as Holton's, Caverly became renowned for his research tracking polio epidemics and investigating methods of controlling both polio and tuberculosis.<sup>13</sup> By the mid-1910s the emphasis on disinfection and building inspection was slowly giving way to personal cleanliness and medical asepsis as the hallmarks of good public health practice.<sup>14</sup>

But Holton and Caverly also contended with a diversity of opinion among medical doctors in the state. Many physicians, not only in rural Vermont but elsewhere in the nation, were slow to adopt the new public health. Tension between adherents of modern therapeutics and advocates of alternative medical practice, particularly homeopathy, persisted

into the early twentieth century. Only half the doctors in the state were members of the Vermont Medical Society and likely to follow its leadership. Moreover, while the spread of scientific medicine and expansion of public health programs elevated the status of leading physicians in the state who gained government backing, the movement also threatened to erode the private medical practices of local doctors struggling to make a living in small communities around the state. By replacing doctors' prerogatives to determine health practice and disease treatment with government-funded services, from vaccination and quarantines to tuberculosis clinics and sanatoriums, public health provision split the ranks of a contentious profession.<sup>15</sup>

#### FROM SCHOOLHOUSES TO SCHOOL CHILDREN

Even as Holton held tenuous leadership among doctors, he sought the cooperation of state school officials. In his attempt to "protect the people from sources of sickness," Holton increasingly targeted schoolhouses, not only for their unsanitary facilities but also as the location of the spread of childhood diseases.<sup>16</sup> After gaining authority to inspect and regulate school buildings in the first decade of the century, Holton ordered local school directors to close antiquated buildings and relocate schools until improvements were completed. The process relied upon investigations by the sanitary engineer, who tested water samples and inspected plumbing, and cooperation from Vermont's new school superintendents.<sup>17</sup> In this way, Holton hoped to circumvent lax health officers and erode local resistance to improving school buildings, but it was a slow, painstaking process.

While school directors procrastinated in the face of Holton's building regulations, measures to control contagious disease among school children pitted health officers against local school administrators and other community members. Both Holton and Caverly repeatedly complained that local health officers failed to report cases of contagious disease, especially tuberculosis, and to properly quarantine families. Local health officers, many of whom were not doctors, held no authority over children unless they were identified with contagious disease. As one officer noted, making "a good cleaning up" was "not a difficult matter" in diphtheria cases, but "when you have whooping cough, measles, chicken pox, cold, sore eyes and lice it is much more difficult to do anything with them."<sup>18</sup> School administrators had gained modest oversight of pupils' health in 1904, when legislators mandated yearly eye and ear exams for students using testing methods supplied by the state board of health.<sup>19</sup> With the goal of discovering physical problems that prevented children from normal progress in learning, these exams, usually performed by

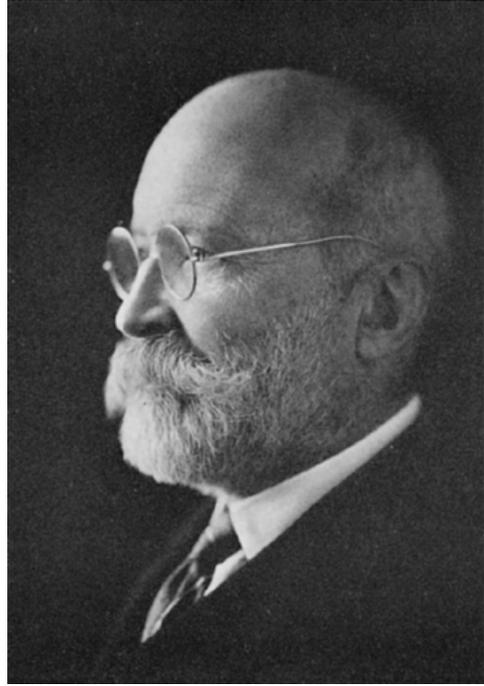
teachers, were hardly satisfactory to Holton and other experts in public health. In 1907 he complained about incomplete and slow reporting and noted that of the 40,296 children examined 32 percent were found to be “defective,” an indication of the poor health of children in the state and the need for better methods of investigation.<sup>20</sup> Moreover, as Randolph’s health officer noted, teachers resisted supervising children’s health because they “dislike to have the number of their scholars cut down.” Another officer reaped “the everlasting displeasure” of a school teacher “for making her lose her work” when he had to close a school after whooping cough spread from the school commissioner’s children to other students.<sup>21</sup> Health officers faced resistance not only from school officials concerned about truancy but from parents as well. Quarantining a family might result in the loss of vital wages if parents were kept from work. In larger commercial centers, widespread quarantines threatened merchants who feared a decline in business from outlying towns. Finally, selectmen chafed at paying state-mandated fees for disease reports and services of health officers, who billed towns for quarantine procedures.<sup>22</sup>

Clearly, Holton would have preferred that the health department supersede school authority over child health, an arrangement that existed in many northeastern cities. There the threat of contagious disease had allowed city health officials to implement medical inspection programs. Responding to an outbreak of diphtheria in 1894, Boston health officials appointed fifty doctors to inspect children, and the New York health department succeeded in instituting a similar effort employing 150 doctors in 1897. Initiated to stem deadly infectious disease, once in place these examinations resulted in the discovery of less serious conditions, i.e., trachoma, head lice, impetigo, ringworm, scabies, conjunctivitis, and problems with sight and hearing. Reformers, who capitalized on public fears that immigrants harbored disease and the desire to Americanize large numbers of immigrant children, began expanding the programs to include hygiene education. But they ignited intense controversy in immigrant neighborhoods. School administrators and teachers resisted the exclusion of children from school; parents, especially mothers, feared the imposition of unknown doctors and other experts over their children’s health; and city physicians resented the use of public funds for free medical care. In New York City immigrant parents provoked a riot in 1906 when school doctors, hoping to improve access to care, set up a school-based clinic to remove children’s adenoids en masse. With the institution of school nurses at the behest of health reformer Lillian Wald, tensions surrounding the program diminished.<sup>23</sup> Wald, who championed state intervention on behalf of children as “a

natural development of ideas held by the founders of the republic," believed that both the school and the home shouldered the responsibility for producing good citizens, including their physical health. Nurses could effectively keep children in school by treating minor problems, ensuring that sick children were treated at city dispensaries, and instructing parents in child hygiene. One of New York City's 650 public health nurses described her role as "the principal's first assistant, the home health visitor, . . . the mother's friend and advisor, and in some communities . . . the truant officer as well."<sup>24</sup>

In Vermont, Holton gave little consideration to nurses' abilities to mediate conflicts over school medical inspection as he began his effort to replace female teachers as examiners with more highly trained male physicians. He invited a public health expert from Massachusetts, where school directors appointed and funded school doctors, to address health officers in 1910, and probably persuaded Brattleboro's representative in the Vermont legislature to introduce a bill enabling medical inspection. Passed with little debate because it was not a mandate, the law and subsequent regulations carefully avoided conflicts with private practice by prohibiting inspectors from prescribing treatment and requiring parental notification and referrals to family physicians. By 1914, however, only eleven towns had voted to institute medical inspection; at least eighteen had turned it down.<sup>25</sup>

In Brattleboro voters readily endorsed the concept because local women had raised awareness of public health threats and a local charity agreed to fund the program. But the experiment was hardly what Holton had envisioned. Members of the Brattleboro Woman's Club had focused on tuberculosis prevention and opened the state's first tuberculosis camp for open-air treatment in 1909. The Brattleboro Mutual Aid Association (BMAA), a health service organization run by local women and largely funded by the Thomas Thompson Trust, had provided visiting nurses and nurse attendants for poor and low-income patients since 1907. Chief director of the Thompson Trust, Richards Merry Bradley of Boston, who spearheaded the organization of the BMAA, was dedicated to the idea that poverty could be alleviated through the judicious use of relatively inexpensive nurses and nurse helpers.<sup>26</sup> With the support of mothers in Brattleboro, in 1911 Bradley offered the use of the BMAA's district nurse for the village school as an experiment in medical inspection. Noting that the town was too small to afford a full-time doctor, he believed nurses could not only provide a preliminary diagnosis but also work with families to prevent infection from spreading. Two years later school directors, one of whom was a doctor sympathetic with Bradley's views, justified the expense as a means to eliminate epi-



*Richards M. Bradley, trustee of the Thomas Thompson Trust and advocate for school nursing. “with interest” 4 (December 1926), 2.*

demics. Other doctors, however, were divided on the issue. Contending that nurses would have no authority under the state board of health and it would be illegal to hire them, Holton insisted that the work remain “in the hands of the medical profession alone.” Nonetheless, the village school district hired a nurse in the belief that she would cause a “minimum of friction” and jealousy among local doctors.<sup>27</sup> In a similar initiative, leaders of the Burlington Visiting Nurse Association sent a nurse into city schools in 1911; subsequently school directors appointed two medical inspectors while nurses continued their service. After 1915 they were employed part time.<sup>28</sup>

By the mid-1910s the health of school children had also become a priority for political activists in the Vermont branch of the General Federation of Women’s Clubs (VFWC), who organized efforts to strengthen the medical inspection law at the state level. Membership in Vermont women’s clubs had grown dramatically since the organization of the state branch in 1896; by 1915 fifty-two local women’s clubs were affiliated with the state organization, which included 5,032 members. Among the diverse activities of club members, civic improvement, health, and education ranked high. Several clubs, including

those in Bellows Falls, St. Johnsbury, Barre, Windsor, Rutland, and Montpelier, supported district nurses for their communities. Many more worked to educate the populace about the spread of tuberculosis and sold Christmas seals to support tuberculosis care. The legislative committee of the state organization began lobbying about issues of concern to women and children in 1903. As the state secretary noted in 1910, “while every true club woman *pleads* for better opportunities for children, for pure food laws, and higher standards of right living, she *works* for the same.”<sup>29</sup> Medical inspection addressed women’s twin concerns for the health of children and improvement in local school programs. After passage of the 1910 enabling act, the state board of health and the Vermont Women Teachers’ Club urged members of the VFWC to help ensure local implementation. In 1913 leaders resolved to work to “relieve physical defects, [and] educate the young for stronger bodies and more wholesome living.” Senator David Conant of Bradford, whose wife Mary served on the VFWC executive board, introduced the organization’s compulsory medical inspection bill in 1915.<sup>30</sup>

Despite the progressive tenor of the 1915 legislature, the VFWC medical inspection bill faced steep hurdles among lawmakers. Weightier measures—comprehensive school reorganization, workmen’s compensation, and the direct primary—dominated the session. As drafted, the bill required school directors to appoint and fund school physicians approved by the state board of health to examine students, teachers, and janitors in all public, private, and parochial schools, surpassing the former legislation both in the scope of inspections and the imposition of state authority over local school affairs and taxing. Following the state health department’s leadership on the issue, the VFWC had excluded the appointment of public health nurses.<sup>31</sup> Republican legislators showed little support for the new bill and simply bolstered the 1910 law instead. The revision compelled school directors to implement inspection after a positive local vote, allowed parental discretion, and expanded the definition of medical inspectors to include “licensed physicians or trained nurses.”<sup>32</sup> Disappointed at the results of their lobbying effort, a majority of VFWC members continued to insist that “the matter should be under State control,” while favoring “a physician to examine and a nurse to carry out instructions.”<sup>33</sup> Their alliance with public health leaders had failed to overcome apathy about health threats and resistance to a state mandate that might also impact parents’ control over children. Moreover, their proposed bill clearly revealed the priority that women of the VFWC placed on doctors’ expertise.

## RICHARDS BRADLEY AND SCHOOL NURSING

Richards Bradley, on the other hand, delighted in the new legislation providing for school nursing and began promoting the idea throughout Vermont. Familiar with the national social welfare movement through his contacts with Boston's elite charity reformers, Bradley brought a commitment to child health and poverty prevention to his crusade in Vermont. With roots in Brattleboro but connections to the world of Boston Brahmins, Bradley was well positioned to apply experiments in poverty prevention to the Vermont scene. Even as he operated a real estate firm in the city, he dedicated much of his energy to his role as trustee of the Thompson Trust and to health care improvements for poor women.<sup>34</sup> Like many charity leaders, Bradley abhorred welfare handouts; he hoped to substitute a corps of competent nurses and nurse helpers that could prevent illness, address poor women's problems, and above all cut health expenses. After developing the home nursing organization in Brattleboro, he turned his attention to the school nurse, whom he believed could provide a "full, sweeping drag-net piece of continuing work" in both school and home. A health investigator rather than a dispenser of treatment, Bradley's school nurse would not supplant doctors but would act as a local coordinator between school, health officer, and doctor. She could "cope with the vast body of obvious defects" and could "nip many of the epidemics in the bud," Bradley noted, and her "friendly relations" with families would "remedy home conditions."<sup>35</sup> With this broad-based approach, Bradley believed that "self supporting parents" would accept disease prevention as a way to get "the necessary health service for their children cheaply," while the poor would assume that nurse inspections were part of public education "without the feeling of being pauperized." "Proper medical and surgical service for the cure of physical handicaps and defects would be available for all children," he reasoned, "just as instruction is available for the cure of ignorance."<sup>36</sup> For Bradley, school nursing was not just a health program; it was a poverty prevention program using nurses to provide health education and eliminate the need for more expensive charity.

Bradley's approach dovetailed nicely with the interests of the nurses he brought to Brattleboro, female leaders of the BMAA, and to some extent even members of the VFWC. These women's groups were increasingly exposed to the ideas of national social welfare leaders who focused on protecting children as part of their effort to bolster the family under the stress of industrialization and to promote state responsibility for social welfare. In her 1912 report, the superintendent of the

BMAA welcomed the organization of the U.S. Children's Bureau, the first federal department devoted to social welfare, with its focus on the "right of the child to be well born."<sup>37</sup> Women of the VFWC often took their lead in child protection work from the Children's Bureau, whose leaders focused on poverty, particularly rural poverty, as the root cause of infant mortality. Capitalizing on sympathy for infants and children among members of middle-class women's clubs, leaders promoted health and child-rearing programs for poor families and the use of public health nurses. In an effort to redirect an emerging eugenic aspect of the infant welfare movement, the U.S. Children's Bureau encouraged therapeutic health exams for babies. Experiments in school nursing were connected to this movement as Lillian Wald, one of the originators of the Children's Bureau, championed the onset of "public control of the physical condition of children."<sup>38</sup> Even though Bradley's vision of social welfare was somewhat less expansive, he collaborated effectively with these women's groups because he believed in preventive health care to alleviate poverty and reform the poor. Appropriating their focus on children and combining it with his own concern about contagious disease, Bradley noted that "precautions and instructions" available to urban children were "almost entirely lacking to the children of the country districts." A nursing program in the schools, he insisted, would reach parents with "knowledge of how to care for themselves" to avoid "contagion and disease."<sup>39</sup>

With this in mind, Bradley launched his plan to develop school nursing as a means of coordinating the health delivery system, revitalizing rural life, and sustaining the family. Hoping to repeat his success in prodding Brattleboro school directors into action, he employed Anna L. Davis, superintendent of the BMAA and school nurse in Brattleboro, to oversee school nursing in Bellows Falls, Townshend, Springfield, White River Jct., and St. Albans in 1916 and 1917. The village of Rockingham passed school inspection because Bradley offered Thompson money to pay the bill.<sup>40</sup>

Davis supervised the work with the energy and zeal of an ardent social worker as she employed medical diagnoses to eliminate poverty. Finding fertile ground for "a wholesale cleaning up" of children's impetigo, diphtheria, syphilis, and tooth decay, she examined pupils, provided instruction in hygiene and sanitary school rooms, and performed "follow-up work in the families and organization for correcting defects." Not confined to the schoolyard, Davis enlisted local women, overseers of the poor, and reluctant health officers in her efforts to eradicate disease and "degenerates" from every town in her path and to "reconstruct families" in the process. Her report from St. Albans detailed

the way she extended her diagnosis beyond the physical condition of school children and intervened in family life:

Miss Haynes our nurse . . . is going on with the routine examination of children and I am tackling the problem in "the Blocks" an awful district. Negroes and whites marry (or just live together) there. There must be a score of degenerates and feeble minded in those old buildings. . . . This week we took a child with big T.B. abscess from school, 10 live in 2 rooms, father out of work, just back from prison. Got child in Hospital, operated this A.M. Got city physician for sick baby, pneumonia. Got father a job in C.V.R.R. yards. Gave the ladies a job on supplies for sick baby.<sup>41</sup>

Not alone in her approach to health problems, Davis exemplified the "elite corps of nurses" who brought the "gospel of health" to the poor in an effort to conquer disease. As an extension of urban visiting nurse work, school nursing provided a forum for teaching the benefits of scientific medicine and "right living" through attention to child health.<sup>42</sup> Nurse Nina Rogers, who claimed responsibility for the health of 10,000 New York City children, taught young citizens "how to live that disease may be avoided and health maintained"; she believed state intervention would protect children from "parents who are careless, ignorant, or neglectful of their children."<sup>43</sup> For Davis, school nursing furnished access to families who practiced the poor habits that she believed caused poverty. Just as concerned about handouts as Bradley, Davis characterized St. Albans as a "dumping ground for paupers" because a local benefactor had given to the "poor with a lavish hand." Not above taking matters into her own hands, she stopped relief for one family and "personally shipped" a drunken man to Burlington because, she explained, "he was annoying one of *my* families." "I gave him his choice," she noted, "of going with me to Police or R.R. station. He sensibly chose the latter." In this way Davis developed considerable autonomy in her profession, but she also used her "friendly visiting scheme with the families" to force commitments to state institutions that she believed were in children's best interest.<sup>44</sup>

More than a carrier of scientific knowledge, Davis brought all the values of the white, native-born middle class with her even while she helped prevent disease and relieve poverty in Vermont communities. Her approach to the problem was broader than that of Holton or others in the medical profession who sought to conquer disease through modern therapeutics. In her broad sweep, she doubtless failed to understand ethnic or class differences in her efforts to aid the poor. As she identified disease "carriers," Davis also stigmatized the sick poor; they were deserving of medical care but also potentially dangerous. Like her

nineteenth-century predecessors, she disliked direct relief and coupled her assistance with moral judgments that determined who was deserving and who was not. Yet she also brought improved health care to Vermont communities, educated children and adults about sanitation, and taught about modern health practices.

As she traveled around the state, Davis met with some success, especially among middle-class residents, some of whom cooperated in her effort to improve children's health and attack poverty. In Bellows Falls, she encouraged the head of the woman's club to form a charity organization and identified poor children for "the Young People's Society of each church, to sew for and clothe." In St. Albans, Davis induced the local woman's club to develop a "loan closet" with supplies for the school and district nurse. Not only did she rely on the "moral and financial support" of local women, but she also got backing from the mayor, overseer of the poor, school officials, and railroad superintendent. After a year's work in St. Albans, the principal cut short his chapel services to accommodate her hygiene talks. "So I am going to see how much I can do for them," she reported to Bradley, "I, to reconstruct families and get their epileptics and feeble minded under care and they pay toll." Thoroughly "delighted" with the dentists in Bellows Falls, she arranged to have them "take the thirty children that we found with bad teeth, and whose parents are unable to pay." Meanwhile she encouraged Bradley to expand the program, exclaiming, "these Vermonters ought to be most grateful to you & the Fund for giving them this work."<sup>45</sup>

Even as she found support for her work, Davis also encountered considerable resistance from health officers, parents, and some doctors. Reporting on one health officer's inept efforts to combat impetigo, she lamented, "He has every authority to clean it up, yet he fumigates the building." As for most doctors, Davis found that on the one hand, they were willing to let the nurse do the work because they could not "be bothered with these children coming to their offices," but on the other, they "wanted to feel that they were working with her on the job."<sup>46</sup> Davis's assessment may have accounted for the attitudes of some doctors, while others resented nurses who were "offering [patients] for nothing things that they ought to pay for." Doctors were more concerned about school nursing than other public health initiatives because it threatened to erode their fee-for-service practices and relationships with patients in the general population, not just among the poor.<sup>47</sup> Nurses and health officers also met "opposition on the part of the public" to quarantines and other measures needed to prevent contagious disease. Davis concluded from Townshend, Vermont, "the health officer is mad about the whole business."<sup>48</sup> After prodding Springfield's reluc-

tant health officer, she advised Bradley, “you plainly see the need of authoritative backing.”<sup>49</sup>

To that end, Davis sought to expand the school nursing program by gaining support from Vermont officials. Despite Holton’s resistance to public health nurses and Davis’s excessive family intervention, in general nurses’ willingness and ability to further his goals appeared greater than that of health officers or some physicians, whom Bradley noted were often “unable or unwilling to act.”<sup>50</sup> Urging Bradley to seek public backing for “a campaign of education that will reach the mass of homes,” Davis hoped the Vermont Board of Education would establish a department of hygiene to oversee school inspection and health education. At the same time, the Vermont Tuberculosis Association, an arm of the state board of health, was formulating a district health proposal to provide public health nurses statewide.<sup>51</sup> In 1917 Davis became treasurer of the Vermont Conference of Charities and Corrections, a coalition of welfare reformers who had turned their attention to child services, and she urged Bradley to address the conference about the school nursing plan. The “physical health of the country child has fallen below that of the city child,” he explained. As the practical answer to avoiding conflicts among doctors, a school nurse could discover physical problems in children and stem epidemics. Advocating medical inspection in every town, he reassured listeners that as an “advisor, friend and educator to both child and parent,” the nurse would simply make “recommendations to the family” who would then consult a family physician. Appealing to widespread fears that Vermonters were falling behind a nation full of immigrants, Bradley lamented that “the plain independent people of our own kind” are neglected. For her part, Davis stressed the need for hygiene instruction to reach parents through their children, and follow-up work with parents at home. She highlighted mothers’ “lack of knowledge” about the spread of epidemics, citing the case of a woman of “average intelligence” who unknowingly sent her child to school with measles.<sup>52</sup> By emphasizing the importance of health education for parents and the role of nurses in monitoring child health and poor family conditions, Bradley and Davis presented the conference with a means of saving children and the entire community. By mid-1918, Bradley’s experiment in school nursing would reach twenty Vermont towns outside Brattleboro at a cost of over eight thousand dollars of Thompson Trust money.<sup>53</sup>

Meanwhile, the public climate favorable to child prevention work had improved with the onset of World War I, spurring Bradley to use his influence with state officials. But he knew it would take some persuading. “I do not think we shall get the state health and state school author-

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ities together in good shape,” Bradley warned in early 1918, “until we produce conditions of public opinion that will make for cooperation.”<sup>54</sup> War recruiting, which uncovered the poor physical condition of young men, reaffirmed the importance of child health, and Bradley argued that this “widespread condition of physical deficiency” provided grounds for state intervention. Believing that Vermonters would accept health education more readily “through their educational system” than from health officers, Bradley approached Vermont education officials. On his recommendation, Commissioner of Education Milo Hillegas agreed to establish a department of hygiene to oversee the school health program. To secure the cooperation of the state board of health, Bradley offered to fund the appointment of a doctor as head of the department who would supervise a corps of nurses for school inspection and hygiene instruction throughout the state.<sup>55</sup> The plan was designed to avoid doctors’ jealousies at the local level, provide inexpensive medical inspection and hygiene education, and extend state authority without increasing local taxes.

Leaders of the state board of health, however, who hoped to place fully trained doctors in the schools, refused to cooperate with education officials. Despite Bradley’s offer of \$3,500 of Thompson funds, Charles Dalton, who succeeded Henry Holton as secretary of the board of health, suggested that Bradley simply “give us a check” and rejected the “conditions or specifications” over use of the money. Bradley lamented that “the officials have their minds too much set on the importance of their own departments and too little on the needs of the children.”<sup>56</sup> Dalton had extolled school inspection as a means of saving “the child from a life of misfortune and dependence” and eliminating those “embarrassing” military draft examinations, but at the same time, according to Bradley, he sought “to claim complete jurisdiction over all school health work.” For his part, Bradley was not ready to provide funds unconditionally. In a final appeal, he proclaimed that he was simply trying to “give school children a fair chance” and was “not seeking personal or permanent control.”<sup>57</sup>

By fall 1918 concern over child health had spread to the general population. In response to the U.S. Children’s Bureau’s designation of 1918 as “Children’s Year,” the VFWC spearheaded an effort to weigh and measure all children under two years old, setting a precedent for state oversight of child health.<sup>58</sup> But it was the flu epidemic of October 1918 that sparked a local crisis in public health. The extent of the epidemic, which caused 2,146 deaths in Vermont, alerted legislators to the inadequacy of local health officers and the need for centralized control. In an extraordinary move, the state board of health closed public schools and

prohibited all public gatherings throughout the state for a month. Nearly every community experienced a shortage of nurses to operate clinics, and the unprecedented number of orphans resulting from deaths of relatively young adults spurred child welfare advocates to organize the Vermont Children's Aid Society in 1919 to help supervise their care.<sup>59</sup> Kemp R. B. Flint, president of the Vermont Conference of Social Work, widened the scope of the conference to include public health organizations in the state and advocated compulsory medical inspection as one of his top priorities.<sup>60</sup> The epidemic affirmed children's needs and the value of nurses, propelling Bradley to bypass state officials and make an appeal to the newly elected governor to break the stalemate on his plan for district nursing. In a desperate plea, he explained to Percival Clement that the state was wasting education dollars by "turning out every year thousands of children who are heavily handicapped in the battle of life owing to physical defects which it is entirely possible to remedy." Explaining the "conflict of authority" between education and health department officials, he implored Clement to "show the officials that there is a public interest that transcends the importance of any department." Despite his efforts to "give these school children a fair chance," Bradley wielded little influence, as Dalton capitalized on the broader sense of crisis in public health.<sup>61</sup>

#### HEALTH DISTRICTS FOR VERMONT

In 1919 Dalton convinced Vermont lawmakers to institute a new centralized health plan that included medical inspection. Since 1917 he had been promoting the idea of dividing the state into health districts with full-time physicians as health officers to improve disease reporting.<sup>62</sup> Members of the health department remained frustrated with lack of compliance with state health regulations, the increasing number of laymen as health officers, and resistance from selectmen who failed to adequately reimburse local health work. Hoping to place control over infectious disease in the hands of fully trained doctors, Dalton proposed shifting the cost of public health work from local communities to the state general fund. In the wake of the disastrous flu epidemic, he submitted the proposal to the legislature in March 1919. It abolished local health officers altogether and funded a system of ten "sanitary districts," each supervised by a full-time "reputable physician" responsible for public health, including medical inspection in the schools. In an unusual address to the Vermont House of Representatives, Dalton argued that the new sanitary districts would save local dollars spent on health inspections. Playing on fears created during the flu epidemic and a perceived shortage of doctors after World War I, he explained that most

town health officers were not doctors and lacked the knowledge to deal with public health threats. In 1919, 98 physicians and 136 laymen served as health officers.<sup>63</sup> As for the use of school nurses, with his focus on the incompetency of untrained health officers and perhaps recognizing the financial constraints of the plan, Dalton did not recommend employment of public health nurses, whom he envisioned only as auxiliary workers, not as health officers. Relying on his faith in medical science, he failed to comprehend the essential mediating and educational role nurses performed, despite the lobbying efforts of social welfare advocates. Flint of the Vermont Conference of Social Work sought a comprehensive district nurse system, while Elizabeth Van Patten of the Vermont State Nurses Association warned that medical inspection “undertaken by the medical men *alone* [had] proved ineffective” everywhere.<sup>64</sup> Nonetheless, Dalton’s plan passed two days after his legislative speech with only one substantive amendment, allowing parents’ discretion over children’s medical exams in cases of noncontagious disease.<sup>65</sup>

This new centralized health plan represented a radical departure for Vermont government because it removed public health from local control; it superimposed the state medical establishment over local doctors; and it institutionalized state oversight of the health of school children. As early as 1915, the editor of the *Brattleboro Daily Reformer* had voiced concern about the possibility of state-appointed doctors for children and admonished the state board of health, which was “getting a bit too arbitrary in the use of its power.” During the legislative debate in 1919, he expressed support for the employment of “reputable physicians” and acquiesced to the need to subordinate “personal liberty” in the interest of disease prevention, but still feared opening the state treasury to the board of health.<sup>66</sup> Demands placed on the health care system by the war and the flu epidemic appeared as real threats to the public in 1919. As a reporter from the *Bennington Evening Banner* noted, “War upon the various pests that have been let loose upon mankind is in order these days.”<sup>67</sup> Moreover, the new law eased the financial burdens of local selectmen, who would no longer have to wrestle with health officers over fees.

Once the state assumed the cost of school inspection, Dalton claimed that school children in all but eleven towns were “under supervision,” yet it was unclear how ten doctors could effectively examine over 60,000 children attending school in the state. The new district health officers, seven of whom had served as health officers in Vermont towns and five who had experience as sanitary officers in the U.S. Army, applauded the new law making them “independent of local influences.” They reported enthusiastically about organizing local health boards in

towns where selectmen had hardly known their duties. Most officers devoted their initial energies to school buildings, many of which they found in deplorable condition; only three officers mentioned medical inspection of school children. By 1921 Dalton could report inspection of 30,082 children, 60 percent of whom were found with health problems, but he lamented that school inspection “might well occupy the entire time of the health officers.” Charles Kidder, a health officer and member of the state board, sought to convince the Vermont Medical Society of the benefits of the program by announcing that nearly all the children in the state were being examined and 80 to 90 percent had “defects,” largely of teeth, tonsils, adenoids, eyes, and ears. In his biennial report, Dalton concluded that Vermont’s organization of public health operated “better than any system yet devised,” placing the state in the “ranks of pioneer work in public health.”<sup>68</sup>

In Vermont communities, however, the success of the program was less obvious, especially to local physicians, many of whom became concerned about the consequences of “state medicine.” Under the new law doctors who had not served as health officers in the past could claim greater control over public health because they were responsible for quarantining patients with contagious disease, billing them, and reporting to the district health officer; former health officers lost income, for they no longer monopolized fees for quarantining. But no local officer was available to supervise residents who declined to see a doctor or were either unable or unwilling to pay their fees. Moreover, a number of towns lacked a doctor qualified to perform the service. Complaints emerged not only over this loophole in the system but also over the excessive number of diseases, including mumps, measles, and whooping cough, that doctors were required to quarantine or face a financial penalty.<sup>69</sup>

Many residents, particularly those in remote rural towns, were confused by the new system as well. It left them bereft of a town health officer who could handle local nuisances and might readily discover families with contagious disease through local sources. To ameliorate the situation in 1921, lawmakers mandated that towns pay doctors or other state board of health appointees twenty-five cents for each contagious disease report and allowed any town to employ a “regularly licensed physician or registered nurse” for health work. In Barnet, for example, the school district voted to have its children examined by the “town’s physician” even though the service was provided by the district health officer.<sup>70</sup> The tradition of town government rendered these new district health officers distant and inaccessible in small towns, while cities with greater resources often funded their own medical inspectors. Lack of

support for the new system dovetailed with complaints from members of the Vermont Medical Society, who argued that the system was “fast becoming unpopular” and unenforceable.<sup>71</sup>

Not only did the new health district system create dissension among doctors over public health, but the development of a variety of free clinics and services also threatened the authority and viability of private practitioners. Since 1916 the state board of health had cooperated closely with the Vermont Tuberculosis Association, a privately funded organization, whose director held a staff position in the state health department. By 1920 the association was sponsoring free chest clinics around the state, employing four public health nurses and a specialist in the diagnosis of tuberculosis, and planning to hire a district nurse for each health unit in the state to expand its free clinics. In addition, the development of local chapters of the Red Cross after World War I initiated an expansion of public health nursing. Elizabeth Van Patten, who directed the work, collaborated with the Tuberculosis Association under the auspices of the state board of health. In 1920 the Red Cross employed eleven district nurses and anticipated nine more. They provided tuberculosis, school, and infant care services and in some districts were responsible for organizing tonsil and adenoid clinics to follow up school inspections. These activities were largely privately funded, but the state board sponsored the work and became closely associated with these efforts. Finally, the U.S. Public Health Service supplied funds for a demonstration in rural hygiene in Windsor County, where a district nurse and “sanitary inspector” operated clinics for removal of tonsils and adenoids.<sup>72</sup>

For leaders in the Vermont Medical Society the specter of expanding public health work threatened both their medical practices and their authority. Public health advocates Dalton and Kidder urged local doctors and dentists to participate in clinics to correct the problems uncovered through inspection of school children, who needed adenoids and tonsils removed and teeth cleaned or extracted. While some doctors participated in “child repair” work, others believed this was simply another burden and objected to this free service that undermined their own practice. At a medical society meeting in fall 1921 members of the organization demanded a conference with all public health agencies in the state and passed a resolution that all clinics “be conducted through the physicians in each locality and not directly with the patient,” and that “those who can pay should be required to pay proportionate to their financial ability.” During the debate doctors voiced their objections to public health nurses. “We don’t want nurses practicing medicine,” one doctor argued, “and we don’t want free clinics to manage the treatment

of disease in our communities.” Others complained that nurses were sending patients to hospitals without consulting doctors. While the head of the Vermont Tuberculosis Association defended the work of his organization and the nurses who performed the work, opponents reiterated their objections to “this public health nurse” and “a society that is digging into our business.” Before the meeting closed, physicians also resolved to oppose the Sheppard-Towner Bill, a measure promoted by the U.S. Children’s Bureau and numerous women’s clubs, which resulted in the first federal appropriation for infant and maternity health clinics.<sup>73</sup>

Even as the Sheppard-Towner Act passed Congress, growing dissatisfaction with public health services among doctors helped dismantle the health district system in Vermont and largely ended school medical inspections in rural areas. In January 1923, Senator George H. Branch, a doctor and former health officer in Grand Isle, introduced a bill to repeal the legislation of 1919 and return local health officers and control over health to Vermont communities. In a budget-slashing mood after the apparent excesses of the Progressive era, lawmakers held little debate over the issue. Appealing to their pecuniary sentiments and the tradition of local control, Senator Branch claimed the new health officers held “swivel chair jobs” and that local selectmen should choose health officers and set their compensation. Indeed, the only significant amendment to the bill returned responsibility for “all compensation for health officers” to selectmen. By February 19 the bill was approved by both houses and signed by the governor.<sup>74</sup>

The repeal of Vermont’s centralized public health administration represented both the interests of local physicians and a “back-to-the-town” movement that dominated state politics. Newly elected Governor Redfield Proctor, Jr. swept into office in 1923 determined to reduce the size of government, and lawmakers debated numerous economy measures, from eliminating administrative departments to ending the district superintendent system and farmers’ indemnification for TB-infected dairy cows. Coupling the district health system with other Progressive-era reforms, one representative characterized it as “one of these new-fangled, expensive, long-distance forms of government.”<sup>75</sup> In this context, opposition to repeal was limited to rural northern counties; few voices touted the financial benefits of the public health system. In large towns, where officials faced greater public health dangers, city councils and school boards were able to fund limited programs without state support.<sup>76</sup>

For Charles Dalton, the repeal represented the end of a lifelong effort to put Vermont “in the forefront among all the states” in public health work. He held his position as secretary of the board of health until 1947, but his zeal for the work diminished. In early 1924 he lamented

that 107 nonmedical men held health officer positions and “the list changes from month to month.” As the state retreated from its supervision over child health, only school boards in larger towns, such as Burlington, Brattleboro, Montpelier, Springfield, Barre, St. Albans, Richford, and Bennington, continued to support school inspection work. In this effort, they collaborated with private visiting nurse associations, women’s clubs, or the Red Cross, with occasional help from local physicians. Meanwhile, the enactment of the Sheppard-Towner Act in 1921 meant that \$5,000 of federal funds were available for infant welfare clinics. Still in its cost-cutting, decentralizing mode, the Vermont legislature refused to pass enabling legislation to receive these funds until 1925, and even then failed to appropriate matching funds in return for an additional federal appropriation. Dalton organized a maternity and infancy division within the board of health with a head nurse who supervised child health conferences and education, but local implementation was left to volunteer women’s groups around the state. Dalton’s goal of correcting “every recognized defect” in the state’s future citizens was unlikely to be fulfilled, at least in the immediate future.<sup>77</sup>

#### CONCLUSION

Vermont’s experiment in public health involved both a debate over local control and a dialogue over who would direct the use of scientific knowledge. In the context of the state’s political structure, defeat of health districts and the accompanying medical inspection program represented another instance of small-town dominance.<sup>78</sup> In this case, despite modest financial incentives, the centralized system of district health officers proved inadequate to serve remote rural towns. An alternative approach employing a larger field force of public health nurses under medical supervision failed to become a political option because advocates for public health disagreed about how to implement the system. They lost political influence to private physicians, who were not only concerned about their practices but also trained to use the new therapeutics primarily to cure patients rather than control disease. Public health doctors, nurses, and social welfare advocates, by contrast, sought to use new scientific knowledge to prevent epidemics and poverty. In northeastern cities, medical inspection succeeded because fear of contagion in crowded neighborhoods was greater, public health nurses effectively eased the perceived threat from ethnic communities, and their services largely overlapped with those of poorly paid doctors in immigrant neighborhoods, not leaders of the medical profession. For both medical and social reformers of the 1910s, the potential benefits of employing nurses, their procurement of medical and dental care for

poor children, and their ability to mediate tensions between schools, doctors, and parents, outweighed the risk that an overzealous nurse could also abuse her role through excessive intervention in family life. In Vermont, physicians' ability to influence the political process limited both the potential benefits and drawbacks of employing public health nurses.

Preventive health services continued in some of Vermont's larger towns, but little provision was made for medical and dental care of the state's rural children. Passage of the Sheppard-Towner Act in 1921, which specifically targeted rural areas, could have provided funds for nurses at maternal and infant welfare clinics, but Vermont lawmakers were reluctant to support such a publicly funded program because it arose just as the state's experiment in public health failed. Nonetheless, by the middle of the decade Sheppard-Towner had also come under attack from members of the American Medical Association and others, who lobbied successfully to eliminate federal funding for child health work in 1929.<sup>79</sup> Other organizations concerned with child health, such as the Vermont Conference of Social Work and the Vermont Children's Aid Society, concentrated on dependent children, whom they sought to rescue from households they perceived as neglectful or degraded. During the mid-1920s these organizations increasingly aimed to measure mental problems in children and sponsored proposals for a comprehensive mental testing program. In that effort, they failed to gain legislative support, but the focus on preventing mental disorders in children dovetailed with the rise of eugenics in the 1920s and helped spawn the Vermont Eugenic Survey begun in 1925.<sup>80</sup>

Meanwhile, advocates for preventive medicine used the Vermont example to boost their case for greater public health service. In 1931, a national survey of preventive medicine for preschool children, including health and dental exams and immunizations, ranked Vermont lowest or next to lowest among twenty-four states. The next year, the authors of a survey of medical facilities deplored the state's high infant mortality rate relative to other white rural areas of the country. Concluding "that something is wrong in Vermont," they targeted the state's inefficient 248 health units, which contributed to "unnecessary deaths and unnecessary physical handicaps."<sup>81</sup> In fact the evidence was mixed; the state's infant mortality rate had declined from 146 in 1910 to 65 in 1930, paralleling the national trend, but it remained above the median among forty-six states and the second highest of the New England states in 1930. Death rates from childhood diseases such as whooping cough and diphtheria had fallen below the national rate.<sup>82</sup> Ironically for Charles Dalton, to cure Vermont's ills, these reformers recommended

dividing the state into county health units and hiring 144 public health nurses under the supervision of the state board of health.<sup>83</sup>

#### NOTES

<sup>1</sup> Anna L. Davis (ALD) to Richards Merry Bradley (RMB), 4 November 1916, Thomas Thompson Trust Papers, Sophia Smith Collection, Smith College, Northampton, Mass. (Cited hereafter as TTTP).

<sup>2</sup> First passed in 1894 and strengthened in 1902, the bovine tuberculosis law remained controversial and a source of legislative debate through the 1920s. See Edwin C. Rozwenc, *Agricultural Policies in Vermont, 1860–1945* (Montpelier, Vt.: Vermont Historical Society, 1981), 97–108.

<sup>3</sup> For local-state relations in the period, see Samuel B. Hand, Jeffrey D. Marshall, and D. Gregory Sanford, "'Little Republics': The Structure of State Politics in Vermont, 1854–1920," *Vermont History* 53 (Summer 1985), 141–166. For Vermont schools, see Michele A. Cross, "Mason S. Stone and Progressivism in Vermont Public Education, 1892–1916," *Vermont History* 62 (Winter 1994), 26–40; and Ruth Zinar, "Educational Problems in Rural Vermont, 1875–1900: A Not So Distant Mirror," *Vermont History* 51 (Fall 1983), 197–220. For an overview of progressivism in Vermont, see Winston Allen Flint, *The Progressive Movement in Vermont* (Washington, D.C.: American Council on Public Affairs, 1941).

<sup>4</sup> Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York: Basic Books, 1994), 226–241; John Duffy, *A History of Public Health in New York City, 1866–1966* (New York: Russell Sage Foundation, 1974), 213–219, 475–488; Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Baltimore: Johns Hopkins University Press, 1990), 92–123.

<sup>5</sup> For the effectiveness of nurses in these programs, see Kraut, *Silent Travelers*, 226–241; Duffy, *History of Public Health in New York City*, 475–488; Barbara Melosh, "The Physician's Hand": *Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982), 131–133; Lillian Wald, *The House on Henry Street* (New York: Henry Holt, 1915), 46–53.

<sup>6</sup> Charles V. Chapin, *A Report on State Public Health Work Based on a Survey of State Boards of Health* (Chicago: American Medical Association, n.d.), 195–196, quoted in Barbara Gutmann Rosenkrantz, *Public Health and the State: Changing Views in Massachusetts, 1842–1936* (Cambridge: Harvard University Press, 1972), 196–197. Chapin gave Vermont 486 out of a total 1,000 points. Massachusetts, the highest-ranked state, received 745 points.

<sup>7</sup> The Massachusetts Board of Health, by contrast, had been in operation since 1869, and urban sanitarians had initiated municipal control over water systems, sewers, and garbage collection in numerous northern cities. See Rosenkrantz, *Public Health and the State*, 55–70; John Duffy, *The Sanitarians: A History of American Public Health* (Urbana and Chicago: University of Illinois Press, 1990), 138–154; Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton: Princeton University Press, 1982).

<sup>8</sup> Vermont, *Acts and Resolves Passed by the General Assembly of the State of Vermont at the Ninth Biennial Session 1886*, No. 93 (Burlington, Vt.: Free Press, 1886); (Vermont statutes cited hereafter as *Laws of . . .*); *Laws of 1892*, No. 82; John Wheeler, "State Administrative Supervision of Town Government in Vermont" (Ph.D. diss., Syracuse University, 1957), 133–137, 144–159; D. Gregory Sanford, "A Pox on All Your Pigs or, Government Acts to Protect the Public's Health," Typescript, 1988. Paper in possession of the author.

<sup>9</sup> B. H. Stone, "Laboratory of Hygiene," *Bulletin of the Vermont State Board of Health* 17 (1 March 1917), 35–47. (Cited hereafter as *BVSBH*.) Joseph H. Linsley of the College of Medicine at the University of Vermont, who had studied under bacteriologist Robert Koch, agreed to set up a chemical and bacteriological laboratory at his own expense; the legislature appropriated \$10,000 for the project in 1900. The lab and related activities boosted Vermont's rating in the AMA survey of 1915 by ten points.

<sup>10</sup> Holton established an annual school for health officers, one of the first in the nation, and often addressed or arranged speakers for the Vermont Medical Society. For the effects of bacteriology on the public health movement, see for example, Duffy, *The Sanitarians*, 193–203; Rosenkrantz, *Public Health and the State*, ch. 3–4.

<sup>11</sup> "Dr. Henry D. Holton," *BVSBH* 17 (1 March 1917), 30–33.

<sup>12</sup> *Brattleboro Reformer*, 18 December 1908; Henry D. Wood, "Medical Inspection of Schools," *BVSBH* 11 (1 December 1910), 11. See also Holton's letters to local officials in Vermont, *Fifteenth (Fifth Biennial) Report of the State Board of Health of the State of Vermont from January 1, 1904, to December 31, 1905* (Rutland, Vt.: Tuttle Co., 1906); and subsequent reports, 1906–07; 1908–09; 1910–11. (Cited hereafter as *Vermont Board of Health Report*.) For legal cases affirming the health

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board's authority, see *State Board of Health v. Village of St. Johnsbury, et al.*, in Vermont, *Reports of Cases Argued and Determined in the Supreme Court of the State of Vermont*, vol. 82 (Burlington, Vt.: Free Press, 1910), 276–286 (quotation on 285); *State v. Duane C. Pierce*, *Ibid.*, vol. 87, 144–151.

<sup>13</sup> “Dr. Charles S. Caverly,” *BVSBH* 19 (December 1918), 10–11. See also Caverly's polio research reports in *Vermont Board of Health Report*, 1910–11; 1913–14; 1916–17.

<sup>14</sup> For the new understanding of contamination, see James H. Cassedy, *Charles V. Chapin and the Public Health Movement* (Cambridge: Harvard University Press, 1962), 110–125. In 1910 Chapin published *The Sources and Modes of Infection*, which became the “bible of the new era.”

<sup>15</sup> For divisions among doctors over public health, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 180–196; Daniel M. Fox, “Social Policy and City Politics: Tuberculosis Reporting in New York, 1889–1900,” in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, eds. Judith Leavitt and Ronald Numbers (Madison: University of Wisconsin Press, 1978), 424–425; “House of Delegates,” *Vermont State Medical Society Quarterly Bulletin* 3 (January 1922), 22–28. For the variety of physicians in Vermont, see John M. McPartland and Patty Pruitt, “Alternative Medicine in Nineteenth-century Vermont,” *Vermont History* 66 (Summer/Fall 1998), 102–111, n.40.

<sup>16</sup> *Vermont Board of Health Report*, 1902–03, 5.

<sup>17</sup> For Holton's letters to school directors, see *Vermont Board of Health Reports*, 1904–1911. For school superintendents, see Cross, “Mason S. Stone and Progressivism,” 30–37. The state board of health gained direct authority over school buildings in 1904 and power to approve school construction plans in 1908. See Vermont, *Laws of 1904*, No. 44; *Laws of 1908*, No. 45.

<sup>18</sup> Wood, “Medical Inspection of Schools,” 9.

<sup>19</sup> Vermont, *Laws of 1904*, No. 44; No. 45. The state school superintendent could directly charge the state treasury up to \$600 to implement this testing. For the expansion of state authority over local schools, see Cross, “Mason S. Stone and Progressivism,” 30–37.

<sup>20</sup> *Vermont Board of Health Report*, 1906–07, 9–10. Use of the term “defect” or “defectives” was common among advocates of preventive health and social services during the period; in this context Holton referred to physical health problems assumed to be correctable. In the 1920s the term gained negative connotations from its use by advocates for mental testing who stigmatized “defectives” as permanent social problems. See Nancy L. Gallagher, *Breeding Better Vermonters: The Eugenics Project in the Green Mountain State* (Hanover, N.H.: University Press of New England, 1999), 73–74.

<sup>21</sup> Wood, “Medical Inspection of Schools,” 9–11.

<sup>22</sup> Charles Dalton, “The Present Status of Public Health Administration in Vermont,” *Vermont State Medical Society Quarterly Bulletin* 2 (April 1920), 26–27. After 1902 health officers received fifteen cents for each report of contagious disease and \$1.00 for each biennial report; after 1904, they could bill towns “the same as for ordinary professional services” for quarantining and disinfection. With the approval of the local health board, the health officer could also bill for the expense of medical treatment for poor patients. See Vermont, *General Laws of the State of Vermont Relating to Public Health*, 1911; Vermont, *Laws of 1910*, No. 217.

<sup>23</sup> Duffy, *Sanitarians*, 210–212; Cassedy, *Charles V. Chapin*, 133–136; Duffy, *Public Health in New York City*, 213–219, 474–488; Kraut, *Silent Travelers*, 226–254; Leavitt, *Healthiest City*, 72–75; Lillian Wald, “Medical Inspection of Public Schools,” *Annals of the American Academy of Political and Social Science* 25 (January–June 1905), 290–296.

<sup>24</sup> Wald, “Medical Inspection of Public Schools,” 298; Nina Rogers Struthers, *The School Nurse: A Survey of the Duties and Responsibilities of the Nurse in the Maintenance of Health and Physical Perfection and the Prevention of Disease among School Children* (New York: G.P. Putnam's Sons, 1917), 27.

<sup>25</sup> Wood, “Medical Inspection of Schools,” 3–6; Vermont, *Laws of 1910*, No. 73; *Vermont Board of Health Report*, 1910–11, 15–17; Vermont Department of Education, *School Report*, 1913–14, 39.

<sup>26</sup> A Boston-based charity, the Thomas Thompson Trust served the “poor seamstresses, needle women, and shop girls” of Brattleboro and Rhinebeck, New York. For activities of the trust and the BMAA, see Marilyn S. Blackwell, “Entitled to Relief: Poor Women, Charity, and Medicine, 1900–1920” (Ph.D. diss., University of Massachusetts Amherst, 1996), 188–220.

<sup>27</sup> *Brattleboro Reformer*, 21 July 1911; 16 July 1913; 22, 23 August 1913; ALD to RMB, 24 February 1917; quotation from RMB to Percival W. Clement, 13 November 1918, TTTP.

<sup>28</sup> “Discussion,” *Proceedings of the Second Annual Vermont Conference of Charities and Corrections Held in Montpelier January 24 and 25, 1917*, 29. (Cited hereafter as VCCC.)

<sup>29</sup> Minute Book, 1907–1921, 120, Vermont Federation of Women's Clubs Papers, Vermont Historical Society, Montpelier, Vt. (Cited hereafter as VFWC Papers.) For women's club work nationwide, see Karen J. Blair, *The Clubwoman as Feminist: True Womanhood Redefined, 1868–1914* (New York: Holmes & Meier, 1980). For women's politics, see Paula Baker, *The Moral Frameworks of Public Life: Gender, Politics, and the State in Rural New York, 1870–1930* (New York: Oxford University Press, 1991), ch. 5.

- <sup>30</sup> Minute Book, 1907–1921, 175–177, 250, 268, 281 (quotation on 232–233), VFWC Papers.
- <sup>31</sup> Vermont, *Senate Bills*, January Session, 1915.
- <sup>32</sup> Vermont, *Journal of the Senate of the State of Vermont Twenty-Third Biennial Session 1915* (Montpelier: Capital City Press, 1915), 282, 331, 418, 474, 510; Vermont, *Journal of the House of the State of Vermont Twenty-Third Biennial Session 1915* (Montpelier: Capital City Press, 1915), 520, 624–625. (Cited hereafter as *Journal of the Senate* and *Journal of the House*.) It is unclear whether Richards Bradley, who promoted school nursing, or the presence of a Democrat and homeopathic physician on the House Public Health Committee, influenced this outcome. The House member who insisted upon the clarifying language was from Londonderry and held ties to Brattleboro.
- <sup>33</sup> Minute Book, 1907–1921, 295, VFWC Papers.
- <sup>34</sup> For Bradley's biography see Mary R. Cabot, *Annals of Brattleboro, 1681–1895* (Brattleboro, Vt.: E. L. Hildreth, 1921–22), vol. 2, 730–731; *Brattleboro Daily Reformer*, 11 February 1943.
- <sup>35</sup> Richards M. Bradley, "School Nursing in Vermont," *VCCC*, 24–27.
- <sup>36</sup> RMB to Dr. A. I. Miller, 21 February 1918, TTTP.
- <sup>37</sup> *Brattleboro Mutual Aid Association: A Neighborhood Association for Mutual Help in Sickness, Fifth Annual Report* (Brattleboro, Vt., 1912), 4.
- <sup>38</sup> Wald, *House on Henry Street*, 49. For the infant welfare movement, women's activism, and the Children's Bureau, see Robyn Muncy, *Creating a Female Dominion in American Reform* (New York: Oxford University Press, 1991), ch. 2; Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890–1930* (Urbana: University of Illinois Press, 1994), ch. 2–3; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), ch. 9; Meckel, *Save the Babies*, ch. 8. For an interpretation stressing the eugenic aspect of the infant health movement, see Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890–1920* (Ithaca: Cornell University Press, 1993), 16, 31–42, 136–171.
- <sup>39</sup> RMB to Charles A. Williams, 21 January 1916, TTTP.
- <sup>40</sup> *Brattleboro Daily Reformer*, 8 March 1916.
- <sup>41</sup> ALD to RMB, 13 January 1917?, TTTP.
- <sup>42</sup> Melosh, "Physician's Hand," 113–125; Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900–1930* (New York: Garland Publishing, 1989), 87–100; Mary S. Gardner, *Public Health Nursing* (New York: Macmillan, 1916; 3rd. ed., 1936), 27–45. See also Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (New York: Cambridge University Press, 1987), 109–111.
- <sup>43</sup> Struthers, *School Nurse*, 3.
- <sup>44</sup> ALD to RMB, 13 January 1917?; "Summary of School Health Work," 10 December 1917, TTTP.
- <sup>45</sup> ALD to RMB, 13 January 1917?; 8 March 1917; 21 November 1916, TTTP.
- <sup>46</sup> ALD to RMB, 12 January 1917; 4 November 1916, TTTP.
- <sup>47</sup> Melosh, "Physician's Hand," 130; Merrill Champion, M.D., "Again, What of the Public Health Nurse?" *Public Health Nursing* 15 (February 1923): 69, quoted in *ibid*.
- <sup>48</sup> ALD to RMB, 4 and 24 November 1916, 12 January 1917, TTTP. For similar resistance to public health programs stimulated through private funding in the rural South, see William A. Link, *Paradox of Southern Progressivism, 1880–1930* (Chapel Hill: University of North Carolina Press, 1992), 283–295.
- <sup>49</sup> ALD to RMB, 4 November 1916, TTTP.
- <sup>50</sup> RMB to Albert W. Varney, 13 November 1918, TTTP.
- <sup>51</sup> ALD to RMB, 24 February 1917; 4 and 21 November 1916, TTTP; *Vermont Board of Health Report*, 1916–17, 7.
- <sup>52</sup> ALD to RMB, 24 February 1917, TTTP; Bradley, "School Nursing in Vermont," 24–29.
- <sup>53</sup> RMB to Percival W. Clement, 13 November 1918, TTTP. For expenses of the trust, see Lucile Eaves and Associates, *A Legacy to Wage-Earning Women: A Survey of Gainfully Employed Women of Brattleboro, Vermont, and of Relief Which They Have Received from the Thomas Thompson Trust* (Boston: Women's Educational and Industrial Union, 1925), 57.
- <sup>54</sup> RMB to Dr. A. I. Miller, 21 February 1918, TTTP.
- <sup>55</sup> RMB to Albert W. Varney, 13 November 1918, TTTP; Milo B. Hillegas, "The Health of School Children," *BVSBH* 18 (1 September 1917), 2–7.
- <sup>56</sup> RMB to James Hartness, 23 August 1918; RMB to Dr. A. I. Miller, 21 February 1918, TTTP.
- <sup>57</sup> Charles F. Dalton, "Public Health Service," *Proceedings of the Third Annual Vermont Conference of Social Work Formerly Vermont Conference of Charities and Corrections Held in Rutland January 23 and 24, 1918*, 35 (cited hereafter as *VCSW*); RMB to Percival W. Clement, 13 November 1918, TTTP.
- <sup>58</sup> For Children's Year, see Klaus, *Every Child a Lion*, 162–170, 257–260; Muncy, *Female Dominion*, 98–99; Meckel, *Save the Babies*, 200–205; L. Josephine Webster, *The First Fifteen Years, 1919–1934: The Vermont Children's Aid Society* (Burlington, Vt., 1964), 14.

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<sup>59</sup> Michael Sherman, "Spanish Influenza in Vermont, 1918–1919," paper read at the Center For Research on Vermont, 13 October 1993; *Burlington Free Press*, 25 November 1918; 19 March 1919; 7 May 1919; Webster, *First Fifteen Years*, 10–13.

<sup>60</sup> K. R. B. Flint, "President's Address," *VCSW*, 1919, 3–5.

<sup>61</sup> RMB to Percival W. Clement, 13 November 1918, TTTP.

<sup>62</sup> Charles Dalton to John Harvey, 23 January 1917, Governor Horace Graham Papers, Vermont State Archives, Montpelier, Vt.

<sup>63</sup> "District Health Officers for Vermont," *BVSBH* 19 (March 1919): 2–6; "Notes From the Sanitary Districts," *BVSBH* 20 (December 1919): 11–18; Vermont, *Journal of the House*, 1919, 334–336, 388; Dalton, "Present Status of Public Health Administration," 26; *Burlington Free Press*, 13 and 19 March 1919.

<sup>64</sup> Flint, "President's Address," 4; Elizabeth P. Van Patten, "Possibilities of Public Health Nursing in Vermont," *VCSW*, 1919, 18–19.

<sup>65</sup> Vermont, *Journal of the House*, 1919, 450; *Journal of the Senate*, 1919, 379.

<sup>66</sup> *Brattleboro Daily Reformer*, 3 and 10 March 1915; 18 March 1919.

<sup>67</sup> *Bennington Evening Banner*, 21 March 1919.

<sup>68</sup> *Vermont Board of Health Report*, 1920–21, 5–6; Charles W. Kidder, "Some Health Problems for Vermont," *Vermont State Medical Society Quarterly Bulletin* 2 (April and July 1921), 25. Kidder's percentage of children with problems was probably an exaggeration designed to convince doctors of the value of medical inspection. Another health officer at the same meeting reported that 30–50 percent of children had health problems.

<sup>69</sup> "Discussion," *Vermont State Medical Society Quarterly Bulletin* 2 (April and July 1921), 30–36; *Rutland Herald*, 10 January 1923.

<sup>70</sup> Vermont, *Laws of 1921*, No. 87, 100; *Caledonia Record*, 15 January 1923.

<sup>71</sup> "Discussion," *Vermont State Medical Society Quarterly Bulletin* 2 (April and July 1921), 26–36 (quotation on 30).

<sup>72</sup> Van Patten, "Public Health Nursing," 40–45; *Vermont Board of Health Report*, 1920–21, 6–7; [Ada Mayo Stewart], *We Who Serve: A Story of Nursing in Vermont* (Burlington, Vt.: Vermont State Nurses Association, 1941), 76–84.

<sup>73</sup> "House of Delegates," *Vermont State Medical Society Quarterly Bulletin* 3 (January 1922), 23–27. For passage of the Sheppard-Towner Act, see Skocpol, *Protecting Soldiers and Mothers*, 480–506.

<sup>74</sup> Vermont, *Journal of the Senate*, 1923; *Laws of 1923*, No. 119; Vermont, *Legislative Directory*, 1923, 406–407. For Branch's comments see *Caledonia Record*, 2 February 1923; *Montpelier Evening Argus*, 31 January 1923.

<sup>75</sup> *Burlington Free Press*, 9 February 1923.

<sup>76</sup> For modest opposition to repeal, see *St. Albans Messenger*, 8 February 1923; *Hardwick Gazette*, 1 February 1923; and *Caledonia Record*, 2 February 1923. For concern about also losing school and highway support, see *Orleans County Monitor*, 14 February 1923. For support for repeal, see *Brattleboro Daily Reformer*, 11 January 1923; *Rutland Herald*, 10 January 1923; the *Burlington Free Press* appeared neutral.

<sup>77</sup> For Dalton's remarks, see *Vermont Board of Health Reports*, 1920–21, 6; 1922–23, 5; 1926–27, 21; "Some Health Problems for Vermont," *Vermont State Medical Society Quarterly Bulletin* 2 (April and July 1921), 29. For school nursing, see [Stewart], *We Who Serve*, 80–83, 93. For Sheppard-Towner, see Ladd-Taylor, *Mother Work*, 175–178.

<sup>78</sup> For the history of small-town dominance, see Hand, et al., "'Little Republics.'"

<sup>79</sup> Skocpol, *Protecting Soldiers and Mothers*, 513–522; Meckel, *Save the Babies*, 208–219.

<sup>80</sup> Gallagher, *Breeding Better Vermonters*, 59–69.

<sup>81</sup> Allon Peebles, ed. *A Survey of the Medical Facilities of the State of Vermont* (Chicago: University of Chicago Press, 1932), 96–97, 106, 125–130 (quotation on 129).

<sup>82</sup> The infant mortality rate is the ratio of deaths under one year of age to 1,000 live births. For these statistics in 1910, see Vermont, *Board of Health Report*, 1910, 1014, 1056. For the 1930 comparison see U.S. Department of Commerce, Bureau of the Census, *Birth, Stillbirth, and Infant Mortality Statistics for the Birth Registration Area of the United States 1930. Sixteenth Annual Report* (Washington: U.S. Government Printing Office, 1934), 27–28. For contagious disease statistics, see U.S. Department of Commerce, Bureau of the Census, *Mortality Statistics 1930. Thirty-First Annual Report* (Washington: U.S. Government Printing Office, 1934), 17–25.

<sup>83</sup> Peebles, *Survey of the Medical Facilities*, 130.