

‘For the Convenience and Comfort of the Persons Employed by them’: The Lowell Corporation Hospital, 1840–1930

JANET GREENLEES*

Centre for the Social History of Health and Healthcare, Glasgow Caledonian University,
Cowcaddens Rd, Glasgow G4 0BA, UK

Abstract: The first industrial hospital in America opened in 1840 in Lowell, Massachusetts. The Lowell Corporation Hospital was sponsored by the town’s textile employers for ninety years. This article analyses the contextual complications surrounding the employers’ sustained funding of the hospital. Motivations for sustained sponsorship included paternalism, clinical excellence, business custom, the labour situation in Lowell, civic duty and the political advantages of paternalism. By analysing the changing local context of the hospital, this article argues that a broader, more integrated approach to healthcare histories and institution histories is needed if we are to fully understand the myriad of healthcare providers and their local and national importance.

Keywords: Lowell Corporation Hospital, Gilman Kimball, Industrial Hospital, Corporate Healthcare, Paternalism

Introduction

In 1840 the first industrial hospital in America opened in the country’s principle cotton manufacturing town of Lowell, Massachusetts. It was sponsored by the local textile employers who were collectively known as the Lowell Corporation. They provided most of the town’s employment and dominated the town council. The Corporation wanted to ‘establish and maintain a hospital for the convenience and comfort of the persons employed by them respectively when sick or needing medical or surgical treatment and to contribute the funds necessary for that purpose’.¹ Individual firms contributed funds in proportion to their employee numbers. Patients were only expected to pay their room and board (initially \$1.75 per week for women and \$2.75 per week for men). Moreover, according to some accounts, if workers could not afford this then their employer provided

* Email address for correspondence: Janet.Greenlees@gcu.ac.uk

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¹ *Articles of Agreement of the Lowell Hospital Association, November 1839* (Boston: Cassady and March, 1839), 3; *Annual Report of the Lowell Hospital Association, January 1, 1888* (Lowell: Vox Populi Press, 1888), 3.

a surety to the corporation that was to be repaid when the patient recovered.² For twenty-seven years this was the only hospital in Lowell and all city residents could use its services. While the hospital benefited the city it was not a profitable venture. Despite this, the hospital operated on the same financial basis for ninety years. In 1930 the declining New England textile industry combined with skyrocketing medical costs meant the remaining textile firms could no longer support the hospital. Rather than close it, the corporation essentially gave the hospital to the Boston Archdiocese for \$1.

The Lowell Corporation Hospital (LCH) was a unique nineteenth-century employer healthcare initiative. While later in the century other employers, including railroad, timber and mining companies, also established complex medical and beneficial organisations to care for workers, these innovations were frequently reluctant and limited efforts to minimise accident costs, improve workers' loyalty and decrease turnover. Very few initiatives included employer-funded hospitals.³ Instead, most large employers held formal or informal arrangements with physicians, contributed to a local dispensary and, later in the century, they endowed hospital beds for workers.⁴ Hence the Lowell Corporation Hospital was both atypical and much earlier than other employer healthcare initiatives.

Through telling the story of the LCH this article argues that hospitals, and indeed any institution, cannot be understood outside of the complexities of their changing context. To that end, this article first explains why Lowell manufacturers chose to invest in a hospital when alternative forms of medical care were available in the city and at a time when hospitals offered little in the way of therapeutics that were not available outside hospital walls. It highlights how the first physician and surgeon, Dr Gilman Kimball, was central to the early success of the hospital. He placed the hospital firmly in line with medical thinking and ensured the hospital fulfilled both employer and community needs, while also making it a centre for gynaecological excellence. Next, the paper reveals how, during the latter half of the century, hospital contributions became a philanthropic custom entwined within business culture. The hospital had become a community resource, providing services for both adults and children. It treated both workplace and street injuries, for which extensive outpatient facilities were developed. The textile firms met their financial obligations from custom and without complaint. Lastly, this paper considers how the hospital faced the economic challenges of the early decades of the twentieth century. Scientific and medical advancements led to skyrocketing healthcare costs. However, the employers sustained their unwavering commitment to the hospital, viewing it largely as a form of paternalistic welfare, but with some political benefits. To these ends, this article draws on a wide

² Sources conflict about whether this was indeed the case. It is also unclear how many patients actually repaid this debt, whether any interest was charged or what the penalties were for non-payment. *Turner's Lowell Directory* states 'If the patients are able, they are to pay to the Superintendent; if not able, the corporations from which they go are responsible, and the patients are then responsible to the corporations'. *Turner's Lowell Directory and Annual Register for the Year of our Lord 1846* (Lowell: Pillsbury and Knapp, 1846), 35.

³ Mark Aldrich, *Death Rode the Rails: American Railroad Accidents and Safety* (Baltimore: Johns Hopkins, 2006), 156; Henry J. Short, *Railroad Doctors, Hospitals, and Associations: Pioneers in Comprehensive, Low Cost Medical Care* (Lakeport, CA: Shearer/Graphic Arts, 1986); Larry Lankton, *Cradle to Grave: Life, Work, and Death at the Lake Superior Copper Mines* (New York: Oxford University Press, 1991), ch. 11; and Alan Derickson, *Workers' Health, Workers' Democracy: The Western Miners' Struggle, 1891–1925* (Ithaca, NY: Cornell University Press, 1988), 86–154.

⁴ Aldrich, *ibid.*, 156, 157; Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 21–22; and Morris Vogel, *The Invention of the Modern Hospital: Boston, 1870–1930* (Chicago, IL: University of Chicago Press, 1980).

range of primary sources, including hospital records and annual reports, city directories, Board of Health reports, workers' letters, transcribed oral histories, newspapers, medical society papers, medical journals and legislation. Combined, they provide the broad local context necessary for understanding the institution and its development and provide a multi-layered picture of the business complexities surrounding operating hospitals.

This contextual analysis of the Lowell Corporation Hospital extends existing hospital histories which have traditionally emphasised either how hospitals were medical and social institutions or the internal workings of the hospital.⁵ Less is known about the complicated contexts that influenced their course and longevity. This paper also advances histories of the social welfare movements and employers' welfare that have stressed health insurance.⁶ It utilises a unique consortium of mill owners to illustrate the motivations and limitations of the business elite who funded early hospitals. Their substantial, sustained investment in the LCH was entwined with the Lowell community, philanthropy, business needs and, to an extent, state politics. These cannot be separated because local and state peculiarities determined the nature and course of healthcare provision in Lowell. Work, with all its connotations, derivations and definitions, affects not just the health of the individual or that of the community, but it also impacts the locally available healthcare. Within the complicated context of the Lowell Corporation Hospital, healthcare became both a community-specific and a political diagnosis. An unintended outcome was that the textile employers essentially invented what is now labelled corporate healthcare.

⁵ Rosenberg, *ibid.*; Rosemary Stevens, *In Sickness and In Wealth: American Hospitals in the Twentieth Century* (New York: Johns Hopkins University Press, 1989); Vogel, *ibid.*; David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (New York: Cambridge University Press, 1982); John H. Warner, 'Power, Conflict, and Identity in Mid-Nineteenth-Century American Medicine: Therapeutic Change at the Commercial Hospital in Cincinnati', *The Journal of American History*, 73, 4 (1987), 934–56; Helena M. Wall, 'Feminism and the New England Hospital, 1949–1961', *American Quarterly*, 32, 4 (1980), 435–52; Joel Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore, MD: Johns Hopkins UP, 1995); Sandra Opdycke, *No One was Turned Away: The Role of Public Hospitals in New York City since 1900* (New York: Oxford University Press, 1999); Jeanne Kisacky, 'Restructuring Isolation: Hospital Isolation: Hospital Architecture, Medicine, and Disease Prevention', *Bulletin of the History of Medicine*, 79, 1 (2005), 1–49; Robert Asher, 'The limits of big business paternalism: relief for injured workers in the years before workmen's compensation', in David Rosner and Gerald Markowitz (eds), *Dying for Work: Workers' Safety and Health in Twentieth-Century America* (Bloomington, IN: Indiana University Press, 1989), 19–33; Stephen C. Kenny, "'A Dictate of Both Interest and Mercy'? Slave Hospitals in the Antebellum South', *Journal of the History of Medicine and Allied Sciences*, 65, 1 (2010), 1–47, especially 5 and 7; Katherine Bankole, 'A Critical Inquiry of Enslaved African Females and the Antebellum Hospital Experience', *Journal of Black Studies*, 31, 5 (2001), 517–38.

⁶ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Harvard, MA: Harvard University Press, 1992); Theda Skocpol, *Social Policy in the United States: Future Possibilities in Historical Perspective* (Princeton, NJ: Princeton University Press, 1995); Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill, NC: University of North Carolina Press, 2001); Mark Aldrich, 'Train Wrecks to Typhoid Fever: The Development of Railroad Medicine Organizations, 1850 to World War I', *Bulletin of the History of Medicine*, 75, 2 (2001), 254–89; 288; Aldrich, *op. cit.* (note 3); Alan Derickson, "'To be his own benefactor": the founding of the Coeur d'Alene Miners' union hospital, 1891', in Rosner and Markowitz (eds), *ibid.*, 3–19; Asher, *ibid.*; and Anthony Bale, 'America's first compensation crisis: conflict over the value and meaning of workplace injuries under the employers' liability system', in Rosner and Markowitz (eds), *ibid.*, 34–52.

The Antebellum Lowell Corporation Hospital: Combining Benevolence, Corporate Strategy and Clinical Excellence

From the start, Lowell was an exceptional city and its history is well documented.⁷ Located only twenty-three miles (thirty-eight km) north of Boston on the Merrimack River, the men who built the town's mills were at the same time independent investors and a group of local entrepreneurs who cooperated on matters mutually beneficial to themselves and the town. They advertised to the world that their workforce of young women, initially recruited from outlying New England farms, was well housed in supervised company boarding houses, well paid, well fed and intellectually active. Moreover, the employers believed it their paternalistic duty to look after their workforce and they expressed a genuine interest in their employees' well-being.⁸ This approach succeeded because parents allowed their daughters to live and work in Lowell. On the other hand, the Lowell mill women were not the loyal, passive workforce that employers had hoped. By the mid-1830s, the Yankee mill-women, who cherished their independence and rights as daughters of freemen, were organising strikes to protest wage reductions and rising boarding house rates.⁹ While strike success was mixed, collectively they signalled to employers that a change of business strategy was needed to reassert their authority and control and prevent labour legislation. This included the planning of the LCH in the late 1830s.

The building of the Corporation Hospital was a visible sign of the employers' welfare paternalism. It also addressed Massachusetts physicians' growing concerns about the health of women and children employed in cotton factories.¹⁰ Medical and political debates about the impact of factory conditions on workers' health increased during the panic of 1837 and the ensuing depression which lasted through the 1840s.¹¹ At the same time, paternalistic philanthropy held business practicalities. Caring for sick workers meant that not only would they return to work more quickly, but the hospital prevented them from returning home, possibly never to return. It extended the employers' authority into yet another area of the women's lives while also serving their business agenda.

The complexities behind the founding of the Lowell Corporation Hospital increase when it is placed within the existing healthcare matrix of Lowell. The LCH was not the employers' first healthcare initiative. When the city's first mayor, the physician Elisha Bartlett, opened a dispensary in Lowell in 1836 the mill owners contributed funds. While many antebellum employers contributed to dispensaries, the Corporation's contributions helped increase their local political influence. Throughout the nineteenth century, the dispensary was a core healthcare provider in Lowell. Its services and 'medicine

⁷ For example: Thomas Dublin, *Women at Work: The Transformation of Work and Community in Lowell, Massachusetts, 1826–1860* (New York: Columbia University Press, 1979; 1993 edn); Janet Greenlees, *Female Labour Power: Women Workers' Influence on Business Practices in the British and American Cotton Industries, 1780–1860* (Aldershot: Ashgate, 2007); Robert Weible (ed.), *The Continuing Revolution: A History of Lowell, Massachusetts* (Lowell, MA: Lowell Historical Society, 1991); and Lawrence Gross, *The Course of Industrial Decline: The Boott Cotton Mills of Lowell, Massachusetts, 1835–1955* (Baltimore, MD: Johns Hopkins, 1993).

⁸ Dublin, *ibid.*, 77–8.

⁹ For more on the strikes and their outcomes, see Greenlees, *op. cit.* (note 7), 163–6.

¹⁰ Dr Douglas spoke on this issue at the convention of the National Trades' Union in 1835 and 1836. J. Commons, *et al.*, *History of Labour in the US*, I (New York: Macmillan, 1918), 436, as cited in George Rosen, 'The Medical Aspects of the Controversy over Factory Conditions in New England, 1840–1850', *Bulletin of the History of Medicine*, XV, 5 (1944), 483–91: 488, n. 15.

¹¹ Rosen, *ibid.*, 488–9; The Rev. Henry A Miles was a well-known apologist of the factory system who argued mill work was not detrimental to women's health. Rev Henry A. Miles, *Lowell, As It Was, And As It Is* (Lowell, MA: Nathaniel Dayton, 1846).

and attendance [were provided] gratuitously' to all city residents.¹² Similar to other antebellum dispensaries, city officials, bankers, attorneys and local businessmen, including Corporation representatives, comprised the Lowell Dispensary board of managers. Early members included John Clark, Superintendent of the Merrimack Corporation, John Aiken, Superintendent of the Suffolk Manufacturing Company and James Cook, Agent of the Middlesex Corporation. By 1842 they had been joined by representatives from the Appleton, Tremont and Boott Mills.¹³ Dispensary managers quickly realised that it was an inadequate facility for a city whose population had more than tripled in the ten years between 1830 and 1840, from 6,477 to 20,981.¹⁴ Furthermore, the dispensary was destined to become a focal point for the poor. Those who could afford it were already seeking healthcare and advice privately from the growing number of physicians in the city. In 1840, when the hospital opened in the former home of manufacturer Kirk Boott, twenty-eight physicians provided services in Lowell.¹⁵ Hence the Corporation Hospital consolidated the employers' healthcare provision, made it part of the business accumulation matrix and increased their community standing, while also addressing many of the healthcare needs of a rapidly growing community.

The impulse behind most voluntary hospitals typically came from physicians who made alliances with wealthy and powerful sponsors, with some states also contributing funds.¹⁶ A different pattern emerged in Lowell. In 1839 hospital investors approached the Lowell-based Dr Gilman Kimball (1804–92) to be physician and surgeon to their hospital. Following common practice in securing top hospital positions, Kimball had previous connections with leading Corporation members. He was related through his mother's family to both the Aiken's and Appleton's.¹⁷ Indeed, other relatives of the Lowell elite held positions at Massachusetts General Hospital in Boston.¹⁸ Through patronage, trustees anticipated loyalty. Yet while family connections may have aided the acquisition of key hospital positions, they bore no relationship to the quality of care.

When appointing Kimball, the Corporation could scarcely have imagined that, during his regime, Kimball would ensure the hospital was at the forefront of medical thinking and make it a centre for gynaecological excellence – an unsurprising choice in a city of women. Nor did the Corporation expect Kimball would bring their views into line with current medical thinking. Kimball was a high-profile appointment. He had studied medicine at Dartmouth College, graduating in 1826. He then worked in Boston and attended lectures at Harvard Medical College while regularly visiting the wards of Massachusetts General Hospital. In 1829 Kimball travelled to Paris to study anatomy and surgery at the largest and, in many respects, the best-appointed hospital in Paris – the Hotel Dieu. Here, Kimball

¹² Lowell, *Massachusetts, City Directory* (Livonia, MA: Cole, 1845). James G. Carney, Chairman of Managers and Joseph F. Trott, Secretary and Treasurer. This may have been the predecessor to the Lowell General Hospital.

¹³ George Motley was superintendent of the Appleton Mills; Charles L. Tilden was superintendent of the Tremont Mills; and Benjamin D. French was superintendent of the Boott Mills. Benjamin Floyd, *The Lowell Directory: Containing Names of the Inhabitants* (Livonia, MA: Cole, 1838). Turner's *Lowell Directory and Annual Register* (Livonia, MA: Cole Publications, 1842), x.

¹⁴ A. Eno (ed.), *Cotton was King: A History of Lowell, Massachusetts* (Somersworth, NH: New Hampshire Publishing Co.), 255.

¹⁵ B. Floyd, *The Lowell Directory* (Lowell, MA: Leonard Huntress, 1840), 32–33.

¹⁶ Rosenberg, *op. cit.* (note 4), 105–7.

¹⁷ Kimball's mother Mary was an Aiken. He was also distantly related to John Aiken and Nathan Appleton. My thanks to Martha Mayo, University of Massachusetts, Lowell (UML), Center for Lowell History (CLH), for building this family tree on www.ancestry.com.

¹⁸ Vogel, *op. cit.* (note 4), 5–6.

trained with the head of its surgical department, Baron Guillaume Dupuytren. Dupuytren was the most popular, as well as the ablest teacher of surgery on the continent of Europe. In 1830 Kimball returned with his certificate in surgery and set up practice in Lowell.

When Kimball accepted the Corporation's offer to lead the hospital, he, along with other physicians, viewed hospitals as a way to further medical education and as a source of personal prestige. Through his appointment, Kimball had gained the business and political support needed to ensure personal recognition and the financial support to ensure the viability of the hospital and to counter the public's distrust of doctors' motives.¹⁹ In most towns, hospital sponsorship was promoted as an additional responsibility for the wealthy, alongside funding other community facilities, such as churches and schools.²⁰ Yet while hospital philanthropy converted wealth into status and influence, the Lowell businessmen had already secured their local prominence. They provided civic amenities, including St. Anne's Church, the Lowell Institute for Savings Bank and schools. Individually and collectively, they were the largest employers in town; they provided decent workers' housing; and they dominated the early town council. Therefore the hospital only expanded the Corporation's influence and social standing in the city, it did not create it. Rather, the Corporation Hospital enhanced Lowell's social capital in a way different to the European model cities of New Lanark, Scotland and Norköping, Sweden. In both towns textile employers sought control over all aspects of their employees' working lives. Yet while they provided housing and some civic amenities, their benevolence did not extend to hospital provision.²¹ The unusual decision to invest in the LCH aided the Corporation's goal of making Lowell a model industrial city, helping them earn a reputation as 'good' employers.

Kimball was the driving force behind the success of the Corporation Hospital as a medical venture (see Figure 1). The hospital provided systematised, structured healthcare for the city and helped combat the urban public health problems evident by 1840. Cases of infectious diseases, particularly typhoid, dysentery and smallpox were rising in Lowell during the 1830s and mortality rates were high. To address these public health crises, in 1836 Lowell became one of the first towns in Massachusetts to establish a local Board of Health. The subsequent opening of the Corporation Hospital provided at least the appearance of disease management because typhoid fever was the most prevalent disease amongst operatives. Typhoid and fever cases comprised half the hospital admittances during its first ten years of operation (see Table 1).²² However, the problematic nature of diagnosing specific types of fever cases might exaggerate these figures. While the LCH sought to prohibit contagious diseases, this policy was difficult to maintain if ill workers

¹⁹ *History of the Reading Hospital, 1867–1942* (Reading, PA: The Reading Hospital, 1942), as cited in Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 152; see also 145–79.

²⁰ Donations and bequests rarely covered medical costs at voluntary hospitals. Patients were expected to make up the difference. Starr cites the example of the Pennsylvania Hospital. R. W. Downie, 'Pennsylvania Hospital Admissions, 1751–1850: A Survey', *Transactions and Studies of the College of Physicians*, 32 (1964), 20–35; 25, as cited in Starr, *ibid.*, 154.

²¹ Ian Donnachie and George Hewitt, *Historic New Lanark: The Dale and Owen Industrial Community since 1785* (Edinburgh: Edinburgh University Press, 1993); and A. Ohlander, 'The invisible child? The struggle for a social democratic family policy in Sweden, 1900–1960s', in Gisela Bock and Pat Thane (eds), *Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880s–1950s* (London: Routledge, 1994), 60–72.

²² Eight hundred and sixteen cases of typhoid were recorded out of 1,627 admittances. (UML, CLH), Lowell Hospital Association, Registry of Patients, 1840–87; Gilman Kimball, *Report of the Lowell Hospital Association, from 1840 to 1849* (Lowell: n.p., 1849), 4–6 and 9.

Disease	Total admitted	Died
Typhoid fever	816	41
Dysentery	96	8
Pneumonia	62	2
Bronchitis	54	0
Rheumatism	65	0
Scarletina	28	1
Measles	33	1
Consumption	15	6
Small pox & varioloid	51	6
All others	407	12
Total	1627	77

Table 1: Reasons for admittance to the Lowell Corporation Hospital, 1840–9. Kimball classified a total of seventy-one different diseases admitted to the hospital during these years. Only the most prevalent are listed above. Source: Kimball, *Report, 1849*, 4 and UML, CLH: Lowell Hospital Association, Registry of Patients, 1840–87.

were to be removed from boarding houses. The LCH had no prescribed isolation wards until the 1880s. Instead, Kimball tried to segregate contagious patients. He mandated that wards be smaller than at other urban hospitals with no more than four or five beds. In exceptional cases, such as typhoid, when possible, an entire ward was appropriated to one patient to minimise the risk of contagion.²³

From the start of his twenty-six year tenure at the LCH in 1840, Kimball claimed that he knew ‘of no other hospital where this condition [quietude and small wards] is so strictly enjoyed, and so thoroughly maintained’. His emphasis on disease prevention marked a contrast to elsewhere in America where this was either non-existent or considered ineffective until after Louis Pasteur and Robert Koch made their scientific breakthroughs in bacteriology during the 1860s and 1880s.²⁴ Moreover, Kimball’s efforts were pre-Lister’s development of effective antiseptic techniques in 1867. Indeed, the medical profession was slow to develop an antiseptic conscience because the techniques were difficult to reproduce.²⁵ Hence, from the start, Kimball set high hygienic standards for the LCH which helped secure its medical recognition.

Kimball also emphasised patient-centred care. In his first hospital report of 1849, Kimball stressed how at the LCH patients were visited by one physician only (excepting in cases of consultation), by no assistants and no medical pupils, as was common practice at many hospitals. Treatment comprised holistic care. This was ensured, as ‘in no instance is a patient allowed to witness a death, or know that such an event has occurred in this establishment. Indeed, everything which may be supposed to operate injuriously on the mind or the senses, is most studiously avoided’.²⁶ This regime ensured the hospital was at the forefront of medical thinking.

However, keeping the LCH in line with current medical thinking was not simply for the operatives’ benefit. The Corporation Hospital was also a community resource. The poor

²³ Kimball, *ibid.*, 6–11, 15.

²⁴ Starr, *op. cit.* (note 19), 135.

²⁵ Starr, *op. cit.* (note 19), 156.

²⁶ Kimball, *op. cit.* (note 22), 8.

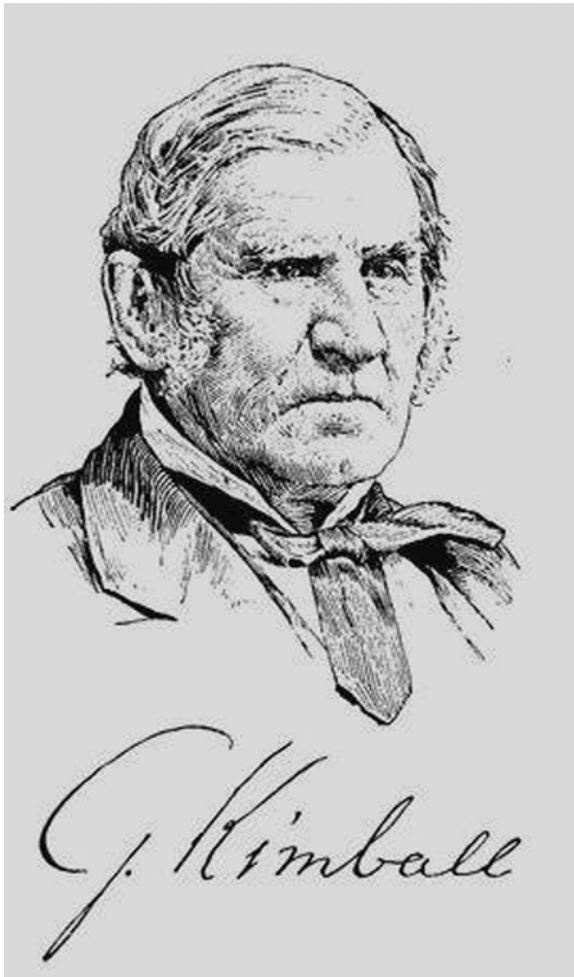


Figure 1: Dr Gilman Kimball, c. 1875. Image courtesy of the Lowell Historical Society, Lowell, Massachusetts.

were not refused. Such a policy addressed the belief widespread in America that medical care was a right for the poor.²⁷ To further enhance its social mission, while also meeting community needs, in 1840 the Corporation Hospital opened a fifteen-bed children's ward. This was the first such facility in Massachusetts. Indeed, the city held high expectations for the hospital. In 1840, the City Directory noted that the Lowell Hospital Association was a new benevolent association that promised 'great good' for the city.²⁸ Civic leaders were convinced that Lowell was becoming a model industrial city.

Despite community expectations, the LCH was not designed simply to be a lodging house for sick workers or a token of charity or to fulfil civic and social needs. Similar to voluntary hospitals, the Lowell Hospital incorporated social supervision into its mission.

²⁷ Charles Rosenberg, 'Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880–1914', *Bulletin of the History of Medicine*, 53 (1979), 346–91: 371–2.

²⁸ Floyd, *op. cit.* (note 15), 28–9.

Company employees who entered the hospital were at the sufferance of their benefactors – in this case, their employers. This corporate control complemented the strict behaviour codes both at work and in company boarding houses. Yet control is only successful when the intended recipients act within the given constraints. While millworkers voluntarily maintained certain behavioural codes, they also sought to preserve their autonomy in the workplace and over their lives as individuals and private citizens. In the factory, women workers sought to retain control over their availability for work, with some success, sometimes staying home to sew or because of bad weather.²⁹ Some of the leaders of the ten-hour movement of the 1840s were Lowell mill women who argued that a shorter day was necessary to preserve workers' health.³⁰ And, while mill workers used the hospital, they also sought to preserve the right to choose their healthcare provider. In addition, because the Corporation Hospital served both community and employee needs, and because alternative medical provision was available in Lowell, viewing the hospital purely as another form of employers' social control must be done with some caution. The LCH served the employers' business agenda but it also provided a community resource. Moreover, because Kimball was such a forceful medical presence, he challenged the employers on certain health issues while also keeping the hospital at the forefront of medicine. By doing so, he brought the Corporation and the city in line with current medical thought.

Kimball's success in raising the profile of the Corporation Hospital was due to both his medical skills and his authority within the hospital. The benefactors of many early American hospitals frequently sat on the boards and held the final decision-making power – not the physicians.³¹ In Lowell, this was not the case. Kimball directed hospital operations. Although not on the board, Kimball's autonomy was such that, when necessary, he freely and openly criticised his employers, the cotton manufacturers. For example, Kimball berated the cotton masters for allowing unhealthy environments in both the mills and boarding houses. He argued that many mills, 'if not all of them, are more or less imperfectly supplied with *pure air*'. Sometimes this was due to the 'mere thoughtlessness or negligence of the overseers'. At other times, production needs determined ventilation, not employee well-being.³² Yet Kimball considered the latter paramount to both production *and* disease prevention. While he acknowledged that certain atmospheric conditions were necessary for production, Kimball argued that poor ventilation contributed to the spread of typhoid fever.

Imperfect ventilation and infection are almost invariably spoken of as associated evils in connection with the origin and prevalence of [typhoid] fever, in the manufacturing towns of Europe; and I very much mistake, if these same evils, though probably to a much less extent, are not found to have a very important bearing upon this same disease as it appears here in the city of Lowell. I am aware that this idea,

²⁹ For example, in 1847 Mary Lucinda Hovey, an operative at the Suffolk Mills in Lowell, called in sick two days at the mills to stay home and sew. Lucinda Hovey to Elizabeth M. Stevens, August 1847 (UML, CLH). For refusing to work in bad weather, see *Fortieth Annual Report of the State Board of Health of Massachusetts* (Boston, MA: Wright & Potter, 1908), 718. Greenlees has demonstrated how some mill women successfully controlled their working hours despite employers' attempts to regulate the working day. *Op. cit.* (note 7), 121–46, especially 132–45. This revises histories that argue Lowell manufacturers increasingly controlled the working day; eg. Dublin, *op. cit.* (note 7), 198–207; and Tamara Hareven and Randolph Langenbach, *Amoskeag: Life and Work in an American Factory-City* (Hanover, NH: University Press of New England, 1978), 1–34, especially 13–28.

³⁰ Dublin, *op. cit.* (note 7), ch. 7; Greenlees, *op. cit.* (note 7), 194–6; and Rosen, *op. cit.* (note 10), 490–1.

³¹ Starr, *op. cit.* (note 19), 151–3.

³² Emphasis in original. Kimball, *op. cit.* (note 22), 13.

particularly as regards infection, has been opposed by some few of our physicians, and in some instances, I fear, with an unfavorable effect.³³

While the employers' response to Kimball's challenge to reform business practices is unknown, Kimball's confidence in his own authority is clear.

Kimball also targeted the Corporation Boarding Houses for health improvements. He claimed ventilation was worse here than in the mills due to overcrowding and negligence in cleanliness.³⁴ Kimball admitted that overcrowding could not be addressed without the Corporation's consent, but argued that there was no excuse for poor cleanliness and not separating ill people from the healthy for 'comparative security to the rest of the household'.³⁵ For Kimball, disease prevention was everyone's responsibility – employer and employee, boarder and boarding house keeper.

During the 1840s, the Corporation increased the health function of the Boarding House Keepers. Rather than simply move sick workers to the 'sick room' in the house, boarding house keepers were now threatened with dismissal if sick operatives did not enter the hospital. Sick workers were threatened with eviction if they did not consent to hospital admittance. In 1849 Kimball wrote to boarding house keepers.

It is requested that all boarding house keepers will use all proper means to induce the sick among their boards to avail themselves of the privileges; and notice is hereby given the neglect or refusal, on the part of any occupant of any boarding house, to carry out this request, will be considered sufficient cause for terminating the occupancy of said house.³⁶

This statement can be interpreted in three ways: as a corporate attempt to force its services on workers; from a genuine concern for employee well-being; or it could be related to the recent death of a boarder. The deceased woman's boarding house keeper was charged and tried for her death because he moved her to another house rather than taking her to the hospital. Hence Kimball's sanctions promoted the hospital as the place for healthcare, reassured parents about their daughters' well-being, while also helping repair the Corporation's image after her death.

Because Kimball argued his case for broad health reforms in the Hospital's Annual Report, Kimball was openly criticising his employers despite having no power of enforcement. Reforming working and living conditions was part of not just Kimball's health reform agenda, but also that of other Lowell physicians. Together, city physicians tackled overcrowding and poor ventilation in all public buildings. Their efforts were rewarded when incidents of contagious diseases in the city declined.³⁷ Indeed, in

³³ Emphasis in original. *Ibid.*, 11.

³⁴ *Ibid.*, 14–15. 'A Visit by an Associationist', in the *Harbinger*, November 14, 1846, 366, as cited in J. R. Commons *et al.* (eds), *A Documentary History of American Industrial Society* (Cleveland, OH: Arthur H. Clark, Co., 1910–1), 10 Volumes, 132. See also Vera Shlakman, 'Economic History of a Factory Town: A Study of Chicopee, MA', *Smith College Studies in History*, XX, 104 (1935), 1–264; 53, 5; and Nancy Zaroulis, 'Daughters of Freemen: the female operatives and the beginning of the labor movement', in Eno (ed.), *op. cit.* (note 14), 105–26; 108.

³⁵ Kimball, *op. cit.* (note 22), 14–15; reprinted in *The Lowell Courier*, 30 July 1849.

³⁶ *Dr Gilman Kimball to the Middlesex District Medical Society* (n.d., c. 1849). My thanks to Martha Mayo, UML, CLH, for this reference. This quote has been incorrectly attributed to Dr Josiah Curtis, 'Brief Remarks on the Hygiene of Massachusetts, But More Particularly of the Cities of Boston and Lowell, Being a Report to the American Medical Association', *Transactions of the American Medical Association*, 2 (1849), 43, by Zaroulis, *op. cit.* (note 34), 117. Kimball reiterates how the sick would be better off in the hospital as it was designed 'for the exclusive purpose of affording every possible comfort, under such circumstances. . .', Kimball, *op. cit.* (note 22), 16.

³⁷ 'Lowell Board of Health', *Minutes 1836–40*.

1849 the local newspaper *The Lowell Courier* acknowledged the physicians' argument about the 'intimate connection between health and cleanliness' and highlighted 'how thoroughly the suggestions of the Board of Health have been carried out'.³⁸ Moreover, these reforms correlated with the broader sanitary movement in both America and Britain.³⁹ Thus Kimball's management of the LCH paralleled broader public health movements.

Despite Kimball's health improvement campaigns and emphasis on hospital care, Lowell residents were slow to turn to the hospital as a primary source of healthcare. This is unsurprising. In antebellum America, healthcare traditionally centred on the family. Outside help was brought in only when necessary. Even then, the burden of responsibility for caring for the sick remained with the family. Until the 1870s hospitals were thought to weaken family ties through separation. Furthermore, many people, including mill operatives, believed hospitals were the last resort for medicine or cures. They were expensive, unnatural and potentially demoralising.⁴⁰ This belief was not without merit. In most cases, a home environment and the nursing care of 'family members provided the ideal conditions for restoring health'. Only the most crowded and filthy dwellings were inferior to the hospital's impersonal ward.⁴¹ Mill workers' letters hint these fears were present in Lowell. On 2 July 1847 weaver Marrilla Williams died from dysentery in the LCH. Her friend, Mary Hovey bemoaned:

how bad to die so far away from all friends who care for you among those whose only wish is as seems to be to have you out of sight that they may get your money and clothes & c. . . . I think the treatments she received during her sickness was anything but fair and when she died it was six o'clock in the morning and she was buried at two in the afternoon & I would just tell you another truth but I dare not put it in black and white.⁴²

However, operatives held diverse perceptions of the LCH. Another weaver, Amy Galusha, wrote matter-of-factly to her family about how she spent one week very ill with varioloid in the LCH in March 1849 and then recuperated in a Lowell boarding house. She did not consider her hospital experience unpleasant.⁴³ Workers' mixed attitudes towards the Lowell Corporation Hospital suggest that, while the hospital probably defended corporate interests, the community recognised that it fulfilled certain health needs for the city.

Over time, the reputation of the LCH grew and the city recognised Kimball's growing medical expertise. These comprised more than disease prevention and public health improvements. While in tenure at the Corporation Hospital, Kimball became a pre-

³⁸ 'Health of the City', *The Lowell Courier*, 22 August 1849.

³⁹ Lemuel Shattuck, *Report of a General Plan for the Promotion of General and Public Health Devised, Prepared and Recommended by the Commissioners Appointed under a Resolve of the Legislature of Massachusetts, Relating to a Sanitary Survey of the State* (Boston, MA, 1850); John Griscom, *The Sanitary Condition of the Laboring Population of New York City* (New York: Harper, 1845). This report is among the first to relate poverty with disease. In Britain, Edwin Chadwick and statistician William Farr led the sanitary movement. See Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain. A Supplementary Report on the Results of a Special Inquiry into The Practice of Internment in Towns* (London: R. Clowes and Sons, 1843).

⁴⁰ Starr, *op. cit.* (note 19), 151; Rosenberg, *op. cit.* (note 4), 21.

⁴¹ Rosenberg, *op. cit.* (note 4), 21.

⁴² UML, CLH: Mary Lucinda Hovey to Elizabeth M. Stevens, 8 August 1847; UML, CLH: Lowell Corporation Hospital Records, Admittance Register 1840–87.

⁴³ Lowell National Historic Park (LNHP): Galusha Letters, Amy Galusha, Lowell Massachusetts to Aaron Galusha, W. Berkshire, 3 April 1849.

eminent gynaecological surgeon. The large proportion of women in Lowell makes this specialism unsurprising. And Kimball was not the sole Lowell physician to choose this specialty or to gain medical recognition for pioneering gynaecological surgery. In June 1853 another Lowell physician, Walter Burnham, performed the first successful abdominal hysterectomy – by mistake.⁴⁴ Later that year, on 1 September, Kimball completed the first deliberate, successful subtotal abdominal hysterectomy for fibroids under chloroform anaesthesia in Boston.⁴⁵ Kimball was also one of the first doctors in America to successfully complete one of the most formidable operations then known in surgery – the ovariectomy. He completed over 300 such surgeries before his death and continually emphasised the importance of antiseptic methods.⁴⁶ In addition, Kimball made significant contributions to the medical fields of gastrotomy and gynaecology with further advances in the oophorectomy, uterine extirpation and the treatment of fibroid tumours by electricity. Having learned the clinical uses of electricity while studying in Europe, Kimball was the first American surgeon to utilise it. These medical achievements gained Kimball both local and national recognition. After leaving the LCH in 1866, Kimball became the first president of the Middlesex North District Medical Society in 1871–72.⁴⁷ And, in 1882, he became the eighth president of the American Gynecological Society (founded in 1876) and was the only officeholder from Lowell throughout the society's history.⁴⁸

Although no surgical cases were listed at the Corporation Hospital until 1857, Kimball's growing reputation as a surgeon secured the hospital broad recognition. Patients and practitioners from elsewhere in America and overseas sought Kimball's expertise, although many surgeries were performed in Boston rather than Lowell. The Corporation benefitted from Kimball's achievements by association. A company hospital with a high profile physician at the helm could not help but raise the Corporation's profile as 'good' employers. Moreover, Dr Gilman Kimball's skills and reputation raised the LCH to a prominence never imagined by the hospital organisers in 1840. This could only have reaffirmed the investors' commitment to the hospital. At the same time, the broader determination of Lowell physicians to improve the health of the city helped place the hospital at the centre of medical provision in the community, while also bringing leading townspeople, including the textile employers, into line with current medical thinking.

⁴⁴ He thought he was removing a large ovarian cyst. Edward Taylor, *History of the American Gynecological Society, 1876–1981 and American Association of Obstetricians and Gynecologists, 1888–1981* (St Louis, MO: CV Mosby, 1985), 31.

⁴⁵ Gilman Kimball, 'Successful Case of Extirpation of the Uterus', *Boston Medical Surgical Journal*, 52 (1855), 249–55; and Thomas F. Baskett, *On the Shoulders of Giants: Eponyms and Names in Obstetrics and Gynaecology* (London: RCOG Press, 1996), 47–8, as cited in Ray Garry, 'The Future of Hysterectomy', *British Journal of Gynaecology: An International Journal of Obstetrics and Gynaecology*, 112 (2005), 133–9; Thomas Baskett, 'Hysterectomy: Evolution and Trends', *Best Practice & Research Clinical Obstetrics & Gynaecology*, 19, 3 (2005), 205–305: 299; M.J. O'Dowd and E.E. Philipp, *A History of Obstetrics and Gynaecology* (New York: Parthenon Publishing Group, 1994); and Elizabeth Ganger (ed.), *Gynaecological Nursing: A Practical Guide* (London: Churchill Livingstone, 2001), 106.

⁴⁶ A. R. Gardner, *History of the Middlesex North District Medical Society, 1844–1944* (Massachusetts Medical Society, 1945), reprinted in *New England Journal of Medicine*, 233 (1945), 29–33.

⁴⁷ *Ibid.*, 12.

⁴⁸ Through 1981. Also, in 1881, the AGS only comprised 60 members, as a high number of applicants were rejected, again illustrating Kimball's medical skills. Taylor, *op. cit.* (note 45), 22.

A Changing Workforce and a Changing City: The Lowell Corporation Hospital in the Late Nineteenth Century

In the late nineteenth century the context surrounding the employers' continued financial support of the Lowell Corporation Hospital changed. Lowell was growing rapidly. The population more than doubled between 1860 and 1890, with immigrants arriving from many countries.⁴⁹ They changed the ethnic and cultural composition of both the city and the textile workforce.⁵⁰ Moreover, an increasingly progressive state legislature sought to reform business practices. Parallel to the rapidly changing social and political environment, Lowell's medical market also changed. St. John's Hospital opened in 1867. Hence the Corporation had to address how the hospital could meet the changing needs of both business and the Lowell community.

The rising immigrant labour force in Lowell held multiple outcomes for employers. The textile employers welcomed them. Immigrants were willing to work for lower wages than native-born workers. New immigrants were less likely to unionise than native-born workers; and they were more likely to allow their children to work in the mills. These benefits all aided the employers' introduction of new technologies and work regimes designed to increase output and lower labour costs, while sustaining shareholder dividends. Labour and shop floor changes also necessitated political manoeuvrings. As wealthy businessmen, the textile manufacturers held strong control of the Massachusetts Republican Party which opposed labour reforms, particularly the post-Civil War resurgence of the ten-hour movement in Massachusetts. At the same time, low wages, poor working conditions and child labour hurt the Corporation's public image.⁵¹ However, Massachusetts lawmakers were some of the most progressive in America and its labour unions the most organised. In 1874 the state legislature passed a ten-hours bill for women and children. This was followed by a maximum hours law, the legalisation of unions, and the outlawing of both blacklists and intimidation.⁵² Their lack of success at preventing labour legislation increased employers' fears about state encroachment in business. They sustained a continuous political lobby against industrial regulation. At the same time, the sustained welfare paternalism evident in the LCH provided a positive focus for outsiders rather than the poor workplace practices. Despite the changing composition of the labour force and the increasing state regulation of business, the employers sustained

⁴⁹ In 1860, Lowell's population was 36,827. By 1890 it had grown to 77,696. In 1870 it was 40,928 and 1880, 59,485. *US Bureau of the Census, Manuscript Returns, Lowell*, 1860, 1870, 1880 and 1890. As cited in Eno (ed.), *op. cit.* (note 14), 255.

⁵⁰ Immigrant culture is part of the revisionist framework that argues immigrants used their cultural background to shape their own destiny. See Tamara Hareven, 'Family Time and Industrial Time: Family and Work in a Planned Corporation Town, 1900–1924', *Journal of Urban History*, 1 (1975), 365–89; Tamara Hareven, 'The Laborers of Manchester, New Hampshire, 1912–1922: The Role of Family and Ethnicity in Adjustment to Industrial Life', *Labor History* (1975), 249–65; and Frances Early, 'The French–Canadian Family Economy and Standard of Living in Lowell, Massachusetts, 1870', in Weible, *op. cit.* (note 7), 235–63.

⁵¹ In 1875 over half of French-Canadian families where the father was unskilled were below the poverty line. Early, *ibid.*, 246–7.

⁵² Legalisation of Unions, *Acts and Resolves Passed By the General Court of Massachusetts in the Year 1888* (Boston: Wright and Potter, 1888), Chapter 134, 99–100; Maximum hours law, *Acts and Resolves Passed By the General Court of Massachusetts in the Year 1890* (Boston: Wright and Potter, 1890), Chapter 375, 339; Blacklists, *Acts and Resolves Passed By the General Court of Massachusetts in the Year 1892* (Boston: Wright and Potter, 1892), Chapter 330, 315; Intimidation, *Acts and Resolves Passed by the General Court of Massachusetts in the Year 1875* (Boston: Wright and Potter, 1875), Chapter 211, 833–4.

their commitment to providing hospital care for their sick and injured workers' and the Lowell community.

As the city of Lowell grew, so too did the choices for healthcare. While the employers sought to sustain the high quality healthcare after Kimball left the LCH, the opening of St. John's Hospital created new challenges. St. John's quickly rivalled the clinical excellence of the LCH through improvements to aseptic techniques.⁵³ Moreover, it was a catholic hospital. Many of the new immigrants to Lowell were catholic, notably the Irish and French-Canadians and St. John's was their hospital of choice. Workers preferred to retain religious and cultural ties and choose their healthcare provider from the many physicians, alternative practitioners and the two hospitals in Lowell.

By 1900 public health improvements meant that fevers no longer comprised the majority of hospital admittances at the LCH. Mill injuries now made up the significant share.⁵⁴ From the Lawrence Manufacturing Company alone, of the 348 injuries occurring between 1899 and 1905, 261 or seventy-five per cent of cases were admitted to the LCH. Rather than wondering if the rising number of accident cases related to deteriorating factory conditions, mill owners instead ascribed workers with a reluctance to use the facility. They complained that amongst mill workers there was a:

Deep and general prejudice prevailing among those who come here for employment, in whose minds the very idea of a hospital has been associated with scenes of anguish and terror; and whose reluctance to become inmates of one is increased by a feeling of independence and a repugnance to submit to such restraint and control as they imagine may be required.⁵⁵

Nevertheless, the employers remained committed to their hospital as both a worker and community facility. Indeed, more people benefitted from the hospital than would benefit from workplace improvements.

As both a community and worker facility, the hospital had to update its services in line with current medical thinking and because of rising healthcare costs. The LCH expanded hospital services and sought efficiencies. During the 1870s and 1880s hospital facilities were modernised. In order to secure their centrality as a community resource, the LCH continued to admit children, while St. John's did not. This rationale sought to encourage the community and particularly families to use the one hospital for all its healthcare needs. Moreover, in June 1877 the Corporation Hospital became the first hospital in the city to open an outpatient department which provided free medical care to all city residents with medicines furnished at cost to the poor.⁵⁶ In 1887 the hospital opened both an isolation ward and a training school for nurses. This was one of the earliest nurse training schools in America and the first in Lowell.⁵⁷ The nursing curriculum at the LCH was similar to

⁵³ Gardner, *op. cit.* (note 46), 7.

⁵⁴ For more on industrial accidents in Lowell, see Carl Gersuny, *Work Hazards and Industrial Conflict* (Hanover, NH: University Press of New England, 1981), especially 68–97; 92–6. Gersuny used the Lowell Hospital Register for 21 September 1899 to 10 November 1905 and the Lawrence Manufacturing Company Collection, vols. G03 and G04 at the Baker Library, Harvard Business School, Cambridge, MA, to trace the fate of injured workers from the Lawrence Manufacturing Company. The hospital records were held at St. Joseph's Hospital (now Saints Memorial). They have since gone missing.

⁵⁵ *Annual Report of the Lowell Hospital Association* (Lowell, MA: Morning Mail Print, 1900), 11.

⁵⁶ *Fifteenth Report of the Medical Staff of St. John's Hospital*, 3 April 1882 (Lowell, MA: Vox Populi Press, 1882), 8; *Annual Report of the Lowell Hospital Association*, 1 January 1888 (Lowell: Vox Populi Press, 1888), 4.

⁵⁷ In 1880 there were only fifteen nurse training schools in the US. Rosenberg, *op. cit.* (note 4), 210, n. 19, US Census. The Training School for Nurses at Johns' Hopkins University opened in October 1889. Janet Wilson James, 'Isabel Hampton and the Professionalization of Nursing in the 1890s', in Morris Vogel and Charles

that of 'some of the best hospitals of [America's] larger cities'. The nursing school was designed to increase hospital efficiency by providing it with an inexpensive, stable and disciplined workforce, while also supplying the community with trained nurses.⁵⁸ The school became 'recognised by all to be far superior to any other plan of hospital nursing'.⁵⁹ Lastly, the LCH was the first hospital in Lowell to appoint a woman physician in 1891 – Dr Sara A. Williams.⁶⁰ Combined, these initiatives addressed a social mission while also reflecting general trends in hospital development in America. They also highlighted the employers' continued benevolence at a time when healthcare debates held prominent public attention.⁶¹ A modern community hospital and welfare paternalism were doubly useful. A hospital cared for the community from which came their labour force, while also helping to sustain a positive corporate image.

By the late nineteenth century too, corporate interest and investment in the LCH had become a business custom. The LCH was an established, successful, community facility. The close networks between city employers and their associated shared values, needs and purposes paralleled individual competitive advantage. Some of the early decisions, particularly the employers' recognition of their responsibility to care for their sick or injured workers, had become routine. For example, during the 1880s and 1890s the Boott Mills were one of Lowell's largest textile employers with a notorious reputation for poor working conditions.⁶² Yet the Boott considered it 'custom' for the firm to pay a doctor 'for employees who get maimed in our mills'. However, free medical care was not an acknowledgement of employer accountability.⁶³ Instead, the altruistic hospital provision held political and ideological meanings. Paternalism was not simply a political tool. It was ingrained within the business matrix and helped to address the challenges of the changing political and social context, while also filling a community need.

The labour unrest and labour reform politics that made Massachusetts the most progressive of the north-eastern textile centres also contributed to the employers' commitment to the LCH. Paternalism limited factory inspections which allowed for labour laws to be broken when desirable. Moreover, the corporate financing of the LCH eliminated the need for any government subsidy which was increasingly necessary at many hospitals, thereby also helping limit state interference in Lowell.⁶⁴ Patching up sick and injured workers was also cheaper than spending vast amounts of money updating and modernising factory machinery. And workplace improvements would only benefit a section of Lowell's population. The employers' sense of civic duty and philanthropy never completely vanished. The reforms introduced at the LCH paralleled the broader hospital reforms occurring throughout America. Hence welfare paternalism held multiple

Rosenberg, *The Therapeutic Revolution: Essays in the Social History of American Medicine* (Philadelphia, PA: University of Pennsylvania Press, 1979), 201–44, 203. When the Lowell General Hospital opened in 1893, it included a training school for nurses.

⁵⁸ *Annual Report, 1888* (note 1), 18. *Report of the Lowell General Hospital* (Lowell, n. p., 1911), 43.

⁵⁹ *Annual Report of the Lowell Hospital Association, 1890*, 18.

⁶⁰ Lowell General Hospital (LGH) was not far behind. James K. Fellows, donor of the Fay Estate which became the Lowell General Hospital, stated that from the hospital's opening there must be 'at least one woman on the staff of attending physicians'. *Saturday Morning Citizen*, 31 October 1891 (LGH was organised and incorporated in 1891 and opened in 1893).

⁶¹ For more on this, see Hoffman, *op. cit.* (note 6).

⁶² See Gross, *op. cit.* (note 7), 24–7, 61–75 and 118–33.

⁶³ *Ibid.*, 72–3; quote from Boott Letterbook, 976; 44, 18 December 1888, as cited on 72, n. 24.

⁶⁴ Stevens, *op. cit.* (note 5), 45–6.

	1903	1914
Employer contributions to operating costs	\$12,600 (54%)	\$32,858.50 (65%)
Patient contributions to operating costs (inpatient & outpatient)	\$8,424.99 (36%)	\$16,339.12 (32%)

Table 2: Income sources for the Lowell Corporation Hospital, 1903 and 1914. Source: Annual Reports, 1903 and 1914. The remaining income was from X-rays and the sale of medicines – primarily the latter.

advantages. While some of these benefits changed during the hospital's life span, the altruism of community hospital provision remained constant.

Medical Advancements, Economic Decline and the Lowell Corporation Hospital in the Early Twentieth Century

Scientific advancements in the years surrounding 1900 not only enabled medicine to do more for patients, they also raised significant challenges for hospital trustees. The Lowell Corporation Hospital trustees still comprised Corporation members. They recognised both the civic and medical needs of continually modernising hospital equipment and facilities and of standardising operations. In 1914 the trustees reported that the additional medical equipment purchased 'provides a much needed increase in our facilities for taking care of larger demands for hospital service'.⁶⁵ Parallel to better medical facilities and the increased use of the LCH went the rising costs of medical technology. These were of concern to Corporation members, despite the swiftly rising dollar value of cotton goods produced in Lowell at the end of the nineteenth century.⁶⁶ Operating costs at the LCH had nearly tripled in the early years of the twentieth century, requiring a substantial increase in corporate contributions (Table 2). The LCH, along with other American hospitals, sought ways to increase their income. They raised board and external charges, sought insurance premiums and tried to lower costs by, among other initiatives, restricting certain services. Ironically, this resulted in making the poor, whom the hospitals were originally meant to serve, a liability.⁶⁷ Curative, not chronic cases were preferred. At the same time, insurance and workers' compensation made medical provision more complicated. Yet in both financing the hospital and providing charity healthcare for Lowell's poor, the LCH distinguished itself from other American hospitals. It retained its social mission and commitment to the community.

The rising insurance premiums posed challenges for hospital finance, some of which a corporate hospital could bypass. Insurance payments had to meet workers' compensation

⁶⁵ For example, 'Report of Trustees', *Annual Report of the Lowell Hospital Association, 1914* (Lowell, MA: n. p.), 12.

⁶⁶ *Census of Massachusetts, 1875; Census of the US, 1890, 1910, 1920; Commonwealth of Massachusetts, Statistics of Manufactures, 1914, 1919, 1921.* The value of product in millions of dollars in Lowell was as follows: 1875, \$16.8 million; 1890, \$19.8 million; 1899, \$17.0 million, including cotton small wares; 1909, \$24.7 million, including cotton small wares; 1914, \$23 million; 1919, \$60.4 million. Figures for 1899 from Charles Levenstein *et al.*, *The Cotton Dust Papers: Science, Politics, and Power in the 'Discovery' of Byssinosis in the U.S.* (Amityville, NY: Baywood Press, 2002), 30.

⁶⁷ Morris Vogel, 'The transformation of the American hospital, 1850–1920', in Susan Reverby and David Rosner (eds), *Health Care in America: Essays in Social History* (Philadelphia, PA: Temple University Press, 1979), 105–16.

laws, particularly the Massachusetts Workman's Compensation Act of 1911, which took effect in 1912. The Act recognised that the cost of injuries should be treated as a production cost. Many hospitals found that the per diem charges for workmen's compensation cases usually did not equal the charges for paying patients.⁶⁸

While hospitals sought to increase their income from insurance companies through accepting workmen's compensation cases, this indirectly increased hospital charges for all patients.⁶⁹ The Lowell situation differed. The employers' financial commitment to the LCH enabled them to avoid some of the problems associated with both insurance and compensation. A corporate hospital minimised insurance costs because it limited certain liabilities and compensation claims against the employers. Yet hospital operating costs were much higher than employers' contributions to an insurance scheme. At the same time, Massachusetts law allowed self-insurance. The Lowell employers' adoption of this practice served to increase the textile firms' financial burden for both their workers and for the hospital. It also may well have contributed to the rise in corporate hospital contributions seen in Table 2. Consequently, rather than following the developing national trend of relationships growing between hospitals and insurance companies, the Lowell Corporation's investment and financing of their hospital took a different path. Their commitment to the hospital required maximising efficiencies and adopting scientific management techniques to deal with the demand for medical services that had more than doubled in the ten years prior to 1914.⁷⁰ While scientific management followed national trends, in Lowell the corporate financing provided a divergent model of hospital care.

From the latter quarter of the nineteenth century hospital management at the LCH paralleled that of other American hospitals. After Kimball, succeeding hospital physicians and superintendants held less autonomy over hospital procedures. They were also less openly critical of their employers, the textile corporation. Indeed, the growth of management structures at the LCH highlights the shift in operational control from the doctors to managers and trustees. Nevertheless, the Corporation continued to absorb most of the operating costs in order to keep patient expenditure manageable, thus preserving their earlier philanthropy.

The Lowell Corporation Hospital's commitment to providing affordable healthcare for Lowell residents remained at a time when hospital governors elsewhere were rapidly increasing charges to meet rising medical costs.⁷¹ As Table 3 highlights, room and board costs at the LCH remained consistently lower than at the other Lowell hospitals and hospitals elsewhere in New England. These charges remained lower through the 1920s. Yet by this time the textile industry was leaving Lowell for southern states where input costs were less. This increased the financial burden of the hospital for those remaining Lowell firms at a time when medical costs were rapidly rising. Moreover, by the 1920s the hospital had moved from the periphery to the centre of both medical practice and the public's experience of severe illness.⁷² Welfare paternalism had become engrained within the Corporation Hospital's mission.

Despite the employers' sustained commitment to their community hospital, operatives still viewed it as only one option for healthcare. Catholic workers still preferred St. John's.

⁶⁸ Vogel, *op. cit.* (note 4), 120–32; Stevens, *op. cit.* (note 5), 88.

⁶⁹ Vogel, *op. cit.* (note 4), 121–3.

⁷⁰ Outpatient numbers increased considerably. Trustees anticipated the hospital would need to expand again in a few years. *Annual Report, 1914* (n. 65), 10–12; and Howell, *op. cit.* (note 5), 32–3.

⁷¹ Vogel, *op. cit.* (note 4), 120.

⁷² Vogel, *op. cit.* (note 4), 119.

Lowell Corporation Hospital (1914)	\$2.05 week women	\$2.75 week men	
St. John's Hospital, Lowell (1916)	Wards \$1.50 per day	Two-bed room, \$2 per day	Private room \$2.50–\$3.50 per day
Lowell General Hospital (1911)	\$7 per week, ward	\$10–\$35 week, private	
Boston City Hospital	\$5 week (1913)	\$7 week (1915)	
Massachusetts General Hospital, Boston	\$10.04 week (1870)	\$15 week (1915)	\$39.90 week (1920)

*Table 3: Comparison of the costs for room and board at three Lowell hospitals and two Boston hospitals. Sources: Report of the Lowell General Hospital for the Year Ending 1 May, 1911, 55; Annual Report of the Lowell Corporation Hospital for the Year 1914 (Lowell, 1915), 5; Annual Report of the Fiftieth Year of St John's Hospital (Lowell, 1916), 10. Vogel, *Invention of Modern Hospital*, 122; Vogel, 'Transformation of the American Hospital', 112.*

Other operatives chose Lowell General Hospital, which opened in 1893, or utilised the many doctors and other healthcare providers in the city.⁷³ For example, women could have their baby free of charge at the Corporation Hospital. During the interwar years, most women mill workers in Lowell, including Valentine Chartrand, delivered their babies at home. However, some, including Blanche Graham, were very poor. Graham had to live with her husband's parents. When she found herself pregnant, she delivered her baby at the LCH 'because they [the Corporation] paid for it'.⁷⁴ Indeed, some workers viewed the hospital as a last choice for healthcare only using it when in poverty or if injured on the job.⁷⁵ Despite the continual increase in healthcare choice in Lowell, the employers' commitment to the hospital as both a community and worker resource remained.

Yet welfare paternalism could not overcome economic realities. As the remaining Lowell textile firms struggled to meet their many financial obligations, the financial

⁷³ In addition to many independent physicians practising in Lowell, alternative therapies held a continuous strong presence. For example, Dr George P. Madden's Hydropathic Institution was well established by the late nineteenth century. Advert in P. J. Lynch, *Souvenir History of St. John's Hospital, Written for the Quarter-Centennial Celebration of the Founding of the Institution* (Lowell, MA: Morning Mail Print, 1892), 89. Father John's Medicine developed at the Lowell pharmacy Carleton and Hovey in 1855 as a non-alcoholic cough medicine for Father John O'Brien. Comprising mostly cod liver oil, it went on to be produced for mass consumption and was initially promoted by Father John. It was produced in the city until the 1980s when production moved to Cody, Wyoming. For more on Father John, see <http://library.uml.edu/clh/Fath/Fath4.Html> (accessed 10 February 2012).

⁷⁴ UML, CLH, Lowell Oral History Collection: The Mill Workers of Lowell. Lowell National Historic Park. Interview with Valentine Chartrand, 8 October 1984, now available online at <http://library.uml.edu/clh/OH/MWOL/Chartrand.pdf> (accessed 19 January 2012); interview with Martha Doherty and Blanche Graham, 12 October 1984, now available online at <http://library.uml.edu/clh/OH/MWOL/Doherty.pdf> (accessed 19 January 2012) (hereafter, Lowell Oral History Collection).

⁷⁵ Lowell Oral History Collection, testimony of Anonymous man, 20 October 1984; Martha Doherty and Blanche Graham, 12 October 1984.

crisis crippled the LCH. With a rising hospital operational deficit, in 1927 the Lowell Corporation decided to sell the hospital. It could no longer afford paternalism which drained vital resources necessary to sustain both a dying industry and shareholders. The sale price was \$85,000 – equivalent to its deficit.⁷⁶ When no buyer was found, in 1930 the Corporation essentially gave the hospital to the Boston Archdiocese (\$1) on condition that the charitable provisions continue for Lowell residents, especially mill workers. Eventually, such extensive charity proved unsustainable. By 1946 the charity funding was depleted. St Joseph's Hospital, as it had been renamed, had to increase board rates.⁷⁷ The civic gospel mentality that had underpinned the hospital for 100 years had finally collapsed under the pressures of economic realities.

Conclusion

This article has identified a unique corporate entity, the Lowell Corporation Hospital, and placed it within its complex, multifaceted context. In Lowell, the industrial elite chose to promote healthcare, and specifically hospital care, as both a worker and community resource. Their ninety-year commitment to such provision was an unusual approach for employers. Yet this commitment meant that the hospital contributed to the economic, social and political diagnosis of Lowell, as well as Massachusetts. To that end, this article has extended voluntary and public hospital histories by demonstrating the complexities behind donor motivations to meet changing local circumstances. Indeed, hospitals, or any institution, cannot be understood outside of their complicated local and national context.

The Lowell Hospital achieved many successes, both as a corporate venture and as a hospital. No other antebellum employers provided a hospital for their workers. The Corporation was strongly paternalistic, which was probably underpinned by a Protestant civic gospel mentality. Over time the employers probably viewed their hospital as a community resource that had grown out of their early dispensary contributions designed to provide healthcare for all Lowell residents. Through the employment of Dr Gilman Kimball the Lowell manufacturers unknowingly set a high standard for healthcare for the city and New England. To that end, the early hospital raised the reputation of both the employers and Lowell as a model industrial city. It also served to consolidate the Corporation's dominance within the city in Lowell, while providing a valuable community resource.

While the Lowell Hospital was exceptional, it was the product of modern medicine in a specific community. Moreover, the ironies of the hospital investment are clear. The Lowell employers invested in a hospital to patch up their sick and injured workers and community residents rather than in prevention strategies. While the altruistic emphasis on curative rather than preventative approaches to health was in line with most American medical services, it is somewhat ironic that the Corporation purchased new medical technology but not new textile machinery. The community and local benefits attached to the hospital were more important than modernising the mill and adopting health and safety measures that would only affect a section of the population. The neglect of the factory environment, unless it posed a public health risk, meant that the hot, humid,

⁷⁶ CLH, Lowell Corporation Hospital Records.

⁷⁷ Saints Memorial Hospital. St. Joseph's Hospital Inc. papers, 1946. Newspaper clipping in 1946 file (n.d., no title). 'Hospital Council of Lowell Announces Increase in Patients' Rates'. However, this was only for accommodation. New rates of \$1.50 per day for adults' accommodation (private, semi-private and ward accommodation). Newborns, children and maternity, 50c to \$1 per day.

dusty working environment contributed to high rates of respiratory disease amongst mill workers.⁷⁸ Moreover, employers were reluctant to install sanitation in the boarding houses or to provide clean drinking water at work. Even in the 1890s workers drank polluted canal water.⁷⁹ While at the time, the employers' hospital gained political and public acclaim, it is the poor working conditions inside the cotton factories which are remembered today. A final irony is that the Lowell Corporation effectively invented what is now labelled 'corporate healthcare'. Yet throughout its existence workers were unsure what to make of the employers' hospital. To them, it was only one option for healthcare from an ever increasing number available in Lowell.

⁷⁸ Janet Greenlees, 'Technological choice and environmental inequalities: the New England textile industry, 1880–1930', in Genevieve Massard-Guilbaud and Richard Rodger (eds), *Environmental and Social Justice in the City: Historical Perspectives* (Cambridge: White Horse Press, 2011), 249–70; and Janet Greenlees, 'Stop Kissing and Steaming!: Tuberculosis and the Occupational Health Movement, 1870–1918', *Urban History* 32, 2 (2005), 223–46.

⁷⁹ S.A. Mrozowski, G.H. Ziesing and M.C. Beaudry, *Living on the Boott: Historical Archaeology at the Boott Mills Boardinghouses, Lowell, Massachusetts* (Amherst, MA: University of Massachusetts Press, 1996), 52–3, 57.