Mayor v. Fairfield Improvement Company:

The Public's Apprehension to Accept Nineteenth Century Medical Advancements

Ryan Wiggins
Daniella Einik
Baltimore Environmental History
December 21, 2009

I. INTRODUCTION

On November 20, 1895, Alcaeus Hooper stood before a crowd of politicians, family, friends, and supporters in Baltimore's city hall. "We feel that the election just held is more than an unusual one," Hooper bellowed, "[t]hat it has amounted to a revolution, and it demands a change in the personnel of the many offices under the control of the municipality. The revolution calls louder, however, for a change in the methods of administration."[1] Hooper was about to be inaugurated as Baltimore's first Republican mayor in a generation. He was a reform candidate who had united Independent Democrats, Republicans, and the Reform League against Isaac Freeman Rasin's Democratic political machine. Political bosses had dominated Baltimore and Maryland politics since the 1870s, acting as middlemen between the city's powerful business tycoons and a governmental structure that they largely controlled. In 1895, reform won overwhelmingly at the state and city level.[2] Many people were eager for a change they could believe in.

In spite of initial gains, including election reform and moves towards greater municipal efficiency, optimism for progressive change in the Hooper administration quickly cooled amongst the Baltimore elite. Hooper refused to acknowledge patronage issues, and in spite of some public support, had considerable trouble with the city council.[3] In early 1897, a dispute over the school board set Hooper and the city council against each other in the Maryland Court of Appeals. In an April 1897 decision, the Court sided with the council.[4]

---

[1] "His Honor, the Mayor: Inauguration of Mr. Hooper, the City's New Executive" *Baltimore Sun*, November 21, 1895.
[2] James B. Crooks, "Politics of Reform: The Dimensions of Baltimore Progressivism" *Maryland Historical Magazine* 71 (Fall 1976), 23-24.
[3] Ibid.
[4] John M. Powell, "History of Baltimore: 1870-1912" in *Baltimore: Its History and Its People, Volume I--History*, Clayton Colman Hall, ed. (New York: Lewis Historical Publishing Company, 1912), 302. Hooper was not merely a reformer. He was also took progressive steps in appointing women to municipal positions, naming Dr. Mary

April, in fact, proved to be an even more difficult month for Hooper, for it was also in that month that City Health Commissioner Dr. James F. McShane informed the mayor that Johns Hopkins Hospital had admitted a very strange patient. That patient, Mary Sansone, became the center of *Mayor and City Council v. Fairfield Improvement Company*. *Mayor v. Fairfield*, though at its most basic level a case of private property rights trumping municipal corporations' police powers, also illuminates larger issues about the professionalization of medicine, the persistence of public opinion, and the law's precarious inhabitance somewhere in between. The following paper first outlines the story behind *Mayor v. Fairfield* and the procedural progression of the case through the court of equity and the Court of Appeals. Second, the paper discusses nineteenth century medical views on leprosy and infectious diseases and the reluctance of the public to accept these medical views. Finally, the paper analyzes how both medical opinion and public perception impacted public health laws and judicial opinions at the time.

II. MARY SANSONE

Mary Sansone was born in 1868 in Baltimore and lived there until 1884. When Sansone turned 16, she travelled to Demerara to stay with her uncle.[5] She stayed a few months before returning to the states. A relatively healthy young person, she married Egnazio Sansone at the age of 20 and had her first child at 23. Unfortunately, the child died while still an infant. She had a miscarriage and was pregnant when she first noticed two mysterious brown spots over her elbow.[6]

Sherwood to the Almshouse Board, Kate McLean to the board of the Female House of Refuge, and Mrs. Edward A. Robinson to the board of visitors to the Baltimore City Jail. While these were not the most important positions in the city, they were certainly steps towards greater equality. Ibid., 298-99.

[5] Her maiden name is unknown.

[6] William Osler, "Leprosy in the United States, With a Report of a Case" *Bulletin of The Johns Hopkins Hospital* 9 (March 1898): 47. Records do not make clear whether her pregnancy when she first noticed symptoms was the miscarriage. Sun articles identify Mary Sansone's husband's name as Eganzio, but an expert on Italian history has speculated that his name was probably Egnazio. James Grubb, conversation with author, Baltimore, MD, March 9, 2009.

Sansone's illness progressed rapidly, affecting her feet and ankles and then her face, legs, and arms.[7] She went to a number of different doctors who prescribed various treatments, none of which proved effective.[8] After watching his wife suffer for six years, Sansone's husband took her to the Pittsburgh City Hospital, informing doctors there that she had been having "scrofulous trouble."[9] Though it became a later point of debate, a physician working in Pittsburgh seems to have diagnosed her with leprosy. The health department in either Pittsburgh or Allegheny City set her up at a local almshouse that planned to construct a frame building within which to quarantine Sansone.[10]

Rather than allow her to be quarantined in the Pittsburgh almshouse, Sansone's husband brought her to Baltimore in early April 1897. The couple stayed with relatives on Dover Street for a few days before Sansone's husband took her to Johns Hopkins Hospital, where she was diagnosed with tubercular leprosy and admitted on April 7. The hospital notified Dr. McShane, the city health commissioner, on April 10 or 12. The health commissioner initially attempted to send the leprous woman back to Pennsylvania.[11] Major James McLaughlin, superintendent of the Allegheny Bureau of Health, refused to take her back. McLaughlin argued that

[7] Ibid., 47-48.
[8] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897 [MSA T53-281, 3/12/2/9], Stenographers Transcript at 80-81, Fairfield Improvement Co. v. Mayor (Dec. 16, 1897). For Sansone's age and family history, see William Osler, "Leprosy in the United States," 47. None of Sansone's family, including the uncle, who eventually moved back to the United States, exhibited any sign of leprosy at any point.
[9] "Death of the Leper," *Baltimore Sun*, September 5, 1899. *Oxford English Dictionary* defines scrofulous as "affected with, or suffering from, scrofula." *OED* defines scrofula as "a constitutional disease characterized mainly by chronic enlargement and degeneration of the lymphatic glands."
[10] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897 [MSA T53-281, 3/12/2/9], Stenographers Transcript at 80-81.
[11] "Miss Douthat's Case," *Baltimore Sun*, January 24, 1898.

> it would be entirely foreign to the practice and usage of properly constituted health departments to insist on the return of such a case, as it might imperil the health and lives of many persons. If the Baltimore authorities attempt to send Mary Sansone here it will be my duty to do all I can to stop them.[12]

Barton Grubbs, director of charities for the city, also refused to care for her, claiming that she had never been registered as a leper there.[13]

While health officials tried to deal with Allegheny City's lack of cooperation, they also faced prejudice from locals. Johns Hopkins Hospital fielded numerous questions about the danger of holding a leprous individual in the city. A Baltimore Sun inquiry about possible infection from entering the hospital led Dr. Henry M Hurd, hospital superintendent, and Dr. William Osler, professor at Johns Hopkins University, to issue official statements. Hurd asserted that the "liability of contagion is almost entirely in using the same knives and forks and drinking from the same vessel as the leper." "Leprosy is not near so easily communicated as tuberculosis and some other diseases that are prevalent in this country," Osler added, "[t]he woman now at Johns Hopkins Hospital could live in her own house, under the supervision of health officials, and not be a source of danger to those about her."[14] Whether the negative public perception of leprosy mattered would become an important issue in the case.

McShane worked diligently to find a place to send Mary. Requests sent to leper colonies in Carville, Louisiana and New York City yielded little. Osler advocated sending the patient to Bayview Hospital.[15] An almshouse at the time, Bayview contained a mental hospital in addition to quarantine facilities for choleric, tubercular, and other contagious diseases. Johns Hopkins

---

[12] "Allegheny City and the Leper Woman," *Baltimore Sun*, June 10, 1897. Admittance and McShane notification dates from BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographers Transcript at 78.
[13] Ibid.
[14] "No Danger of Contagion," *Baltimore Sun*, June 14, 1897.
[15] See, for example, Osler, "Leprosy in the United States," 49. The doctor testified as much during the case. See BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographers Transcript at 68.

University and the University of Maryland jointly ran the almshouse as part of their medical training programs.[16] Bayview did not respond positively to Osler's wishes, arguing that it lacked room and appropriate facilities.[17]

While McShane continued to look for other alternatives, city officials made a last-ditch effort to remove Sansone from Hopkins. The Board of Health authorized the expenditure of $400 to renovate the former house of the resident quarantine physician at the old lazaretto grounds at Fairfield/Wagner Point.[18] The Lazaretto Point hospital burned down in 1836. A new quarantine station, built in Fairfield in 1845, occupied a twenty-acre plot and housed mainly immigrants. It also acted as a pest house for the city until the early 1850s.[19] Most of the Curtis Bay peninsula fell outside of Baltimore's quarantine line, making it the perfect place to establish facilities for the housing of people with contagious diseases. The hospital first came into use for quarantine purposes in 1871.[20]

III. FAIRFIELD IMPROVEMENT CO. V. MAYOR: PROCEDURAL HISTORY

On August 5, 1897, the Fairfield Improvement Company ("Fairfield") filed an initial Bill of Complaint against the Baltimore City Council and the Mayor requesting that the court enjoin the City from moving Mary Sansone.[21] Fairfield Improvement Company owned property adjacent to the Fairfield/Wagner Point hospital grounds. In the initial Bill of Complaint, Fairfield

[16] Toba Schwaber Kerson, "Almshouse to Municipal Hospital: The Baltimore Experience" *Bulletin of the History of Medicine* 55 (1981): 215.
[17] COURT OF APPEALS (Records and Briefs) Mayor & City Council of Baltimore v. Fairfield Improvement Co., 1898, January Term, vol. 4, MSA S1733-121, Appellant's Brief at 2, Mayor v. Fairfield Improvement Co. (Mar. 4, 1898). Kerson, "Almshouse to Municipal Hospital," 215-16.
[18] "Mary Sansone, The Leper" *Baltimore Sun*, July 13, 1897.
[19] Joseph M. Miller, "Vignette of Medical History: Lazaretto Point" *Maryland Medical Journal* 42 (November 1993): 1124.
[20] Philip Diamond, "An Environmental History of Fairfield/Wagner Point" (Paper based on the collective research of the faculty and students in the Fall 1997 Building Baltimore Seminar, University of Maryland School of Law, 1998), 17.
[21] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Bill of Complaint, Fairfield Improvement Co. v. Mayor (Aug. 5, 1897).

argued that Mary Sansone's presence would cause "incalculable loss and irreparable injury" to the land owned by Fairfield because individuals would not buy the property.[22]

On August 13, 1897, Fairfield expanded on its initial complaint. First, Fairfield alleged that the City had abandoned the property as a hospital and pest house, evidenced by the recent burning of all the structures on the property, and that individuals purchased property from Fairfield relying on that abandonment.[23] Fairfield claimed that it had expended a great deal of money in preparing the property for development and that industry had already moved into the area, creating commerce.[24] Fairfield argued that this abandonment and the subsequent reliance prohibited the City from reopening the hospital. Fairfield's second argument was that this woman's presence on the City property would be a public nuisance. Her presence would be a nuisance because the surrounding residents would not be able to feel safe or peacefully enjoy their homes.[25] In addition, Mary Sansone would be a public nuisance because the City planned to leave her in the care of the property's groundskeeper and his wife, denying her adequate care and increasing the likelihood of injury to the surrounding residents.[26]

The Mayor and City Council responded to Fairfield's initial Bill of Complaint on August 13, 1897 and filed an amended answer on August 14, 1897.[27] In its response, the Mayor and City denied that leprosy was an infectious and contagious disease that was dangerous to the lives of

[22] Ibid., 1.
[23] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Amended Bill of Complaint at 2, Fairfield Improvement Co. v. Mayor (Aug. 13, 1897).
[24] Ibid., 1,2.
[25] Ibid., 3.
[26] Ibid., 3,5.
[27] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Answer, Fairfield Improvement Co. v. Mayor (Aug. 13 1897); Amended Answer, Fairfield Improvement Co. v. Mayor (Aug. 14, 1897).

the individuals on the surrounding lots.[28] Defendants also argued that Sansone would be properly cared for because she would be under the care of Health Department physicians in addition to the groundskeeper.[29] The Defendants argued that the city had not abandoned the facility, but rather that it had been in continuous use since 1864. The facility had not seen patients in recent years only because there had not been a need for the facility. [30] As a result, the City argued that Fairfield was not entitled to relief because it purchased the property with knowledge of the hospital's location and could not complain about its presence.[31] The Defendants also refuted Fairfield's point that the City could send the patient to another pest house being used by the City.[32] Finally, the Defendants showed that the City was also expressly authorized by ordinance to quarantine such individuals on property designated by the City outside of the city limits.[33]

On September 10, 1897, the Court granted the Anne Arundel County Commissioners' petition to become plaintiffs. In their petition, the Commissioners argued that they had a duty to protect the residents of Anne Arundel County from public nuisances such as Sansone and thus had an interest in the case.[34] During the bench trial and days of witness testimony, it came to light that Fairfield had actually requested that the Commissioners become a party to the case, not

[28] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Answer at P1.
[29] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Amended Answer at P7.
[30] Ibid., P3. According to defendants' amended complaint, the property was last used during the Smallpox epidemic of 1883. Ibid.
[31] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Answer at P5.
[32] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Amended Answer at P4. The defendants stated that the Hawkins Point hospital is strictly for the quarantine of new arrivals to the city and is not used for housing residents of the city afflicted with contagious diseases. Ibid.
[33] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Answer at P4.
[34] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Petition of County Commissioners of Anne Arundel County Commissioners at P1, Fairfield Improvement Co. v. Mayor (Sept. 10, 1897).

the individual citizens of the county that they claimed to be protecting.[35] It is unclear what Fairfield's motives were in bringing the County Commissioners into the case, but it is possible it was to legitimize Fairfield's main argument that the residents of the area would be impacted by the Defendant's actions.

Judge John Upshur Dennis of the Circuit Court for Baltimore City heard witness testimony on December 16, 1897. Prior to December 16, the court subpoenaed, on behalf of the Plaintiffs, a long list of residents and business owners of Fairfield and Anne Arundel County. In addition, the Plaintiffs called the City Health Commissioner, Dr. McShane.[36] The defendants called one witness, Dr. William Osler, a doctor who specialized in infectious disease at Johns Hopkins Hospital.[37] In the end only a portion of the plaintiff's witnesses actually testified in front of the Judge.

During testimony, the plaintiffs stressed that the Fairfield residents were members of the common public who feared leprosy notwithstanding the current scientific opinion that the disease was not highly contagious. Thus, the public's fear would cause individuals not to buy property in Fairfield.[38] The defendants, on the other hand, stressed that leprosy was not a contagious disease and thus the public fear was unreasonable.[39]

Judge Dennis ruled on December 16, 1897 in favor of Fairfield and issued an order enjoining the City and Mayor from placing Mary Sansone on the property in question.[40] He decided that the City had abandoned the property as a hospital and thus could not reopen the

[35] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographers Transcript at 52 – 53.
[36] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Plaintiffs Witnesses, Fairfield Improvement Co. v. Mayor (Nov. 30, 1897).
[37] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographers Transcript at 56.
[38] *See* Ibid., 9 – 10, 18, 33-37, 50-51.
[39] *See* Ibid., 57 – 59.
[40] BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Decree, Fairfield Improvement Co. v. Mayor (Dec. 16, 1897).

facility. In addition, Judge Dennis found that the market value of Fairfield's property would depreciate. The Judge placed great weight on the fact that the City could easily send her to the other pest hospitals in the city where she would get proper care. The City and Mayor appealed Judge Dennis's decision to the Court of Appeals on January 8, 1898.

The Court of Appeals, in a decision written by Chief Judge James McSherry, affirmed Judge Dennis' decree enjoining the City and Mayor of Baltimore.[41] It balanced the City's duty to protect public health and welfare with a private individual's right to enjoy his property. The Court of Appeals held that the City could not exercise its power in such a way that created a nuisance and impacted individual property owners' enjoyment of their property.[42] The court downplayed the medical view that the disease was not highly contagious. It focused on the sense of dread that the disease conjured in the common public and that this sense of dread remained despite medical opinion. According to the court, the basis for determining a nuisance was not medical science but that the public views of leprosy would cause individuals not to purchase property from Fairfield and thus impact property values.[43]

Further the court ruled that the City had abandoned the property.[44] Fairfield relied on this abandonment when it developed the surrounding property and it did not come to the nuisance.[45] Finally, the Court ordered the injunction because Mary Sansone would not be cared for properly, furthering the possibility of spreading the disease and the creation of a nuisance.[46]

---

[41] *Mayor v. Fairfield Improvement Co.*, 39 A. 1081 (Md. 1898).
[42] *Id.* at 1082-83.
[43] *Id*. at 1084.
[44] *Id.* at 1085. According to the Court of Appeals, the following facts proved that the City abandoned the property: (1) the City last placed patients at the facility in 1883, (2) the City burned all the buildings, and (3) the City issued an ordinance calling for the sale of the property. *Id.*
[45] *Id.*
[46] *Id.* at 1085.

IV. FAIRFIELD, THE CRISPS, AND AN EPILOGUE TO THE CASE

A. Fairfield and the Crisps

By the mid-1800s, the Crisps had become the dominant family on the Fairfield/Wagner peninsula. Though they initially appear to have used the land primarily for agricultural purposes, within a few decades they began to shift focus towards industrial development.[47] In 1878, Baltimore City bought and rebuilt the Light Street Bridge, increasing the viability of building company towns on the peninsula. In 1882, the Baltimore and Ohio Railroad extended to Curtis Bay, further lubricating the wheels of development.[48] By 1893, nine factories, including the Baltimore Chrome Works and Monumental Acid Works, occupied the area. Of chief importance to the development of the area was the establishment of fertilizer processing plants, which had become an important part of Baltimore's trading business since the middle of the century. Fairfield area industry employed 2,100 workers, though only 221 people lived there.[49] In 1891, the Crisps formed the Fairfield Improvement Company, making hundreds of land transfers to and from it. Though they claimed that it was formed to make sale of the land easier, the company also served as a tax shelter.[50] Regardless of the reasoning, the Fairfield Company felt that it needed to protect its considerable investments when the city attempted to move Sansone to the old quarantine grounds.

---

[47] Diamond, "An Environmental History of Fairfield/Wagner Point," 15-16.
[48] Sherry H. Olson, *Baltimore: The Building of an American City* (Baltimore: Johns Hopkins University Press, 1980), 214.
[49] Diamond, "Environmental History," 26-27, 30. One of the most important fertilizer factories, Rasin Fertilizer Company, was owned by RWL Rasin, brother of Isaac Freeman Rasin. To speculate that Mayor v. Fairfield somehow resulted from animosity between the Rasins and Hooper would be an interesting but unverifiable exercise. John Thomas Scharf, *History of Baltimore City and County From the Earliest Period to the Present Day: Including Biographical Sketches of their Representative Men* (Philadelphia: Louis H. Everts, 1881), 397-98.
[50] Diamond, "Environmental History," 26. For Herbert Crisp's description of the purpose of the company, see BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897 [MSA T53-281, 3/12/2/9], Stenographer's Transcript, 57-63.

B. The Death of Mary Sansone

While the litigants awaited the Appellate Court's decision, Sansone remained in the quarantine ward at Johns Hopkins. During her stay, public prejudice continued to act against her. Rumors persisted that Johns Hopkins was going to "throw her out," leading Dr. C. Hampson Jones--McShane's replacement as Health Commissioner--to declare that if it were to happen, he would "take care of her somehow, if I have to take her to the City Hall annex and feed her myself."[51]

In early 1898, Mary W. Douthat, a nursing student in the Johns Hopkins nursing program, caused a stir when she opted to quit the program rather than work in the quarantine ward where Sansone stayed. The nursing school was quick to point out that at least thirty-four other students had willingly served in the quarantine ward since Sansone's arrival and that service there did not even necessarily mean working with that particular patient.[52] Nevertheless, the incident probably did little to prevent even greater public apprehension from developing.

Sansone's husband visited her several times during her stay, but did not continue living in Baltimore. On September 4, 1899, she succumbed to nephritis and died at Johns Hopkins.[53] Efforts were made to contact her husband, but he could or would not come back to Baltimore to claim the body. The city buried her at Western Potters Field on September 7.[54]

[51] "Dr. Jones is Puzzled," *Baltimore Sun*, August 10, 1898.
[52] "Miss Douthat's Case" *Baltimore Sun*, January 24, 1898.
[53] "Death of the Leper" *Baltimore Sun*, September 5, 1899.
[54] "Leper Buried in Potter's Field" *Baltimore Sun*, September 8, 1899.

V. ANALYSIS: *MAYOR V. FAIRFIELD* WITHIN A BROADER PUBLIC HEALTH CONTEXT

A. The Medical Profession in the United States and Baltimore in the Nineteenth Century.

One of the dominant themes of *Mayor v. Fairfield* is the disparity between public perception and medical knowledge. While most researchers and medical professionals would probably point to this as a major issue today, the disparity was all the worse in the latter half of the nineteenth century before the professionalization of American medicine had reached maturity. The organization and professionalization of hospitals began in the mid-1800s as a growing urban population fostered the development of larger, more organized facilities. As doctors began to organize, they also began to publish journals intent on distributing the latest medical understanding and cutting-edge research to an ever-growing professional population.[55] Technology played an increasingly important role as stethoscopes, ophthalmoscopes, and laryngoscopes came into use. By the 1870s, bacteriology had come to play an important part in medical practice, followed by abdominal and gynecological surgery a decade later.[56]

Still, American medicine lagged behind Western Europe, especially Germany, through the 1870s and 1880s. The German model employed the use of large clinics, laboratory work, high standards of training, and benefitted from a generally prestigious reputation. This drew droves of medical hopefuls across the Atlantic from America until the first few decades of the twentieth century.[57] Not to be deterred, Americans soon began to close the gap, and in 1893, Johns Hopkins medical school opened in Baltimore. The school introduced German clinical methodology to American academia. It was built around clinical work in the Johns Hopkins

[55] Rosemary Stevens, *American Medicine and the Public Interest* (New Haven: Yale University Press, 1971), 34-35.
[56] Ibid., 39.
[57] Ibid. From 1870-1914, 15,000 American practitioners spent some period of time in Germany.

Hospital, the same facility where Mary Sansone stayed and also home to a revolutionary nursing school that had opened in 1889.[58]

William Osler became the first chair of medicine at Johns Hopkins.[59] A Canadian who graduated from McGill University in 1874, Osler taught at McGill and later the University of Pennsylvania before coming to Baltimore.[60] He had a tremendous reputation as a reformer, modernizing public healthcare in Montreal and Philadelphia before coming to Baltimore. In Baltimore, he specifically focused on fixing the "notoriously unsanitary conditions that pervaded." The battle against tuberculosis in Baltimore and elsewhere was one of his most enduring contributions to medicine.[61] Though Osler was not an expert on leprosy, his focus on public health and contagious diseases led him to correspond with more informed researchers and medical professionals about the disease well before the Sansone case. Like many other programs during that decade, Hopkins' initial scientific curriculum placed strong emphasis on the study of infectious disease.[62]

Reflecting Progressive Era beliefs in professionalization and state enforcement of moral activity, public health officials in the late nineteenth and early twentieth centuries began to move away from campaigns for general cleanliness in favor of "specific measures directed against specific diseases." As Charles Chapin remarked in his history of the American Public Health Association, "great health movements...teach right ways of living and offer treatment. The

[58] Ibid., 56-57.
[59] Ibid., 57.
[60] Johns Hopkins Medical Archives, "Biography" http://www.medicalarchives.jhmi.edu/osler/biography.htm (accessed November 11, 2009).
[61] Abner McGehee Harvey, *The Association of American Physicians 1886-1986: A Century of Progress in Medical Science* (Baltimore: William and Wilkins, 1986), 34.
[62] Ibid., 92.

physician and the nurse are the chief agents of the new movement. They have taken the place of the sanitary inspector and the policeman."[63]

B. Medical Views on Diseases and Leprosy in the Nineteenth Century

There was a large yet incomplete body of information on the sources and impacts of leprosy available to the City and court at the time of the *Fairfield* case. A widely-read medical textbook from the 1890s defined leprosy as

> A chronic infectious disease caused by the bacillus leprae characterized by the presence of tubercular nodules in the skin and mucous membranes (tubercular leprosy). At first these forms may be separate, but ultimately both are combined, and in the characteristic tubercular form there are disturbances of sensation.[64]

Medical experts were in some disagreement about how exactly one could contract the disease. There had been, for example, a theory that it could be passed from a parent to a child. The accepted consensus at a leprosy conference held in Berlin not long before Sansone's case determined that it could not. By the late 1890s, prominent experts believed that leprosy was most likely passed through the mucous membranes of the skin. However, evidence also suggested that, as with smallpox and other contagious diseases, the clothing of the infected could carry the bacteria.[65] Around the turn-of-the-century, it was known to attack people of any age who had been in extremely close contact with infected individuals. The above medical textbook suggested segregation in cases where the disease was common, like Louisiana and California, and in any other instance where family and friends could not be trusted to provide the patient with proper care and complete isolation.[66]

---

[63] Charles V. Chapin, "History of State and Municipal Control of Disease," in *A Half Century of Public Health* Mazyck P. Raÿenel, ed. (Lynn, MA: The Nichols Press, 1921), 137, cited in Barbara Gutmann Rosenkrantz, "Cart before Horse: Theory, Practice and Professional Image in American Public Health, 1870-1920" *Journal of the History of Medicine and Allied Sciences* 29 (1974): 63.
[64] Osler, The *Principles and Practice of Medicine: Designed for the Use of Practitioners and Students of Medicine* 3rd ed. (New York: D. Appleton and Company, 1898), 338.
[65] Ibid., 340-41.
[66] Ibid., 342.

When Doctors Osler and McShane testified before the court, they verified the difficulty of transmitting leprosy from person to person. Osler pointed to the fact that 500 other people resided within one block of the Hopkins quarantine ward, where Sansone had been for three months, and none had shown signs of leprosy. He went so far as to say that she could be there for fifty years without any other cases showing up.[67] Osler suggested that she be moved to the Bayview Hospital, saying that it would only require the "ordinary, everyday precaution" to protect the other patients from her condition.[68] The two doctors would have undoubtedly agreed with an 1899 medical textbook asserting that, "in this country...such measures [as forced quarantine] would be cruel and inhuman, as they are unnecessary" when dealing with leprous patients.[69]

C. Public Perception of Diseases and Leprosy in the Nineteenth Century

Assuming, as John Geise did in his testimony before the court, that most people regarded leprosy in the same way they would smallpox, yellow fever, or any of the other epidemics that ravaged the United States in the nineteenth century, regardless of what professional medicine told them, the fear of leprosy at Fairfield would have been strongly associated with public experiences with those diseases.[70] Considering the effect epidemic diseases had had on the United States over the course of the nineteenth century, it is reasonable to understand why the public would fear something like leprosy that they associated with more communicable maladies.

---

[67] BALTIMORE CITY CIRCUIT COURT (Equity Paper A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographer's Transcript at 63.
[68] Ibid., 60.
[69] Prince A. Morrow, "Leprosy," in *Twentieth Century Practice: An International Encyclopedia of Modern Medical Science by Leading Authorities of Europe and America* Volume XVIII (New York: William Wood and Company, 1899), 612. Morrow was quick to qualify his statement, adding that he was not opposed to quarantine, but did not find it to be as necessary in the United States as in third world countries.
[70] BALTIMORE CITY CIRCUIT COURT (Equity Paper A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographer's Transcript at 42-43.

Since the formation of the republic, the United States--and specifically Baltimore--had suffered from countless bouts of typhus, yellow fever, smallpox, and other afflictions. In 1794, yellow fever swept through Baltimore, killing 344 people.[71] In 1832, a cholera epidemic struck the East Coast of the United States. In 1866, another devastating cholera epidemic wrecked the East Coast.[72] More immediate still were the epidemics that affected Baltimore in the early 1870s and early 1880s. All of these added together form a reasonable fear that the placement of Mary Sansone at Fairfield might trigger yet another string of death and suffering.[73]

This fear, however, could only be considered reasonable if people disagreed with accepted turn-of-the-century medical theories that asserted leprosy's limited communicability. Unfortunately, the case record shows that the residents of Fairfield were not going to accept this medical knowledge. Of the several businessmen and doctors who testified, everyone felt that the factory workers who inhabited Fairfield perceived leprosy to be a threat.[74] Martin Wagner, president of Wagner Packing Company, claimed that his employees "haven't got sense enough" to know that leprosy was not dangerous. William Crenshaw argued that some people might leave because of Sansone's placement in Fairfield but that, more importantly, others would not come

---

[71] Kerson, "Almshouse to Municipal Hospital," 204. In a city of just under 14,000 people, this had a significant effect. Population from U.S. Bureau of the Census, "Population of 24 Urban Places: 1790" http://www.census.gov/population/www/documentation/twps0027/tab02.txt.

[72] Alan M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York: BasicBooks, 1994), 37. By the 1866 epidemic, the public perception of cholera had begun to change. It had become the general opinion among doctors and lay people that cholera spread through excrement. People no longer assumed, for example, that cholera turned into typhus, recognizing it to be its own disease. Vague understanding of the possibility that microbes might play a part in the condition had also begun to trickle down. An article in the Boston Herald went so far as to call the organisms on that caused cholera and one which Louis Pasteur was working "insects." For more on the cholera epidemics, see Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: The University of Chicago Press, 1962), 198-199.

[73] Between 1850 and the end of the century, Baltimore and Maryland saw no fewer than eight smallpox epidemics, two measles epidemics, two yellow fever and scarlet fever epidemics in addition to bouts of typhus and dysentery. Conservatively, theses attacks led to the deaths of no fewer than 1,300 deaths. Nancy Bramucci, "Epidemics in Maryland" *Medicine in Maryland 1752-1920* http://mdhistoryonline.net/mdmedicine/cfm/dsp_epidemics.cfm. Such fears would only be exacerbated when news began returning of horrendous American losses to typhoid fever during the 1898 Spanish-American War. Harvey, The Association of American Physicians, 85.

[74] Neither the appellants nor the appellees felt it necessary to call actual residents to testify in court; the closest they came was the Fairfield postmaster and an Anne Arundel County doctor.

to live there. John Geise and William Osler agreed that most people, regardless of class, were afraid of leprosy and wanted to avoid it at all costs. Postmaster Bernard Miller made an interesting point, reasoning, "Why everybody is afraid of it. Ain't the people in the city here afraid of it, and you want to give us your rubbish down there in the country where that building is in."[75] This was a difficult point to argue against from the perspective of someone who was not intimately involved in the health department's decision-making process. The fear also seems to have had religious roots. In his answer to the *Baltimore Sun*, C. Hampson Jones complained that "if Christians would only remember less of the Law of Moses and would put into practice the acts of Christ, the leper would be taken care of."[76] Osler's testimony in court amounted to the same, for the doctor complained that Fairfield's residents relied entirely on Biblical teaching, ignoring anything medical professionals said.[77]

Osler and his colleagues were up against a long, formidable tradition of public fear of leprosy. As the doctors pointed out, much of this fear--at least in the Western world--stemmed from certain passages in the Old and New Testaments, most specifically the laws outlined in Leviticus. The Bible defines leprosy as "a rising, a scab, or bright spot...in the skin of the flesh," ordering that when these symptoms appear and "the hair in the plague is turned white, and the plague sight [be] deeper than the skin of [the] flesh," the diagnosed was to be declared a leper by Aaron or one of his progeny in the priestly tribe.[78] These symptoms obviously encompassed more and excluded much of what had come to be called leprosy by the nineteenth century, but nevertheless the treatment, that "[a]ll the days wherein the plague [shall be] in him he shall be

[75] These statements can be found in BALTIMORE CITY CIRCUIT COURT (Equity Paper A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographer's Transcript at 38, 21, 43, 65, and 110-11, respectively. Jones' quote from "Dr. Jones is Puzzled," *Baltimore Sun*, September 10, 1898.
[76] "Dr. Jones is Puzzled," *Baltimore Sun*, August 10, 1898.
[77] BALTIMORE CITY CIRCUIT COURT (Equity Paper A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographer's Transcript at 62.
[78] Leviticus 13:2-3 KJV.

defiled; he [is] unclean: he shall dwell alone; without the camp [shall] his habitation [be]," persisted in the public imagination.[79] More recent events, however, also gave people reason to fear leprosy's spread.

Marylanders living in the late nineteenth century would have been no strangers to leprosy and its effect on their country and around the world. Americans had a long history of associating immigrants with contagious disease, and leprosy was no exception. A 1900 medical textbook claimed that leprosy only occurred in places where "the natives are dirty and promiscuous in their habits, communistic in their modes of living, and who do not fear, but ignorantly invite contagion."[80] Clearly this was a far cry from the clean, orderly lives lived by advanced, Western societies. Osler, when identifying the origin of Mary's case, was quick to assert that "the disease never originates here; all the cases come from countries in which leprosy prevails."[81]

Leprous individuals in the United States were mainly concentrated in just a few major yet well-known areas. The West coast saw a number of cases due to the influx of immigrants from Asia. China was well known to be a source of leprosy and many Christian missionaries from Europe and America went there to establish leprosariums there to help the poor.[82] In America, white California politicians and journalists were already derogatorily referring to the Chinese in terms of the leprosy they brought to the state. During the debates over the Chinese Exclusion Act, California Congressman James A. Johnson exclaimed that were the United States to continue to allow "the Hottentot, the cannibal from the jungles of Africa, the West India negro, the wild Indians, and the Chinamen," to emigrate, America's youth would soon suffer from

[79] Leviticus 13:46 KJV. When one considers that by 1900 Leviticus was part of an estimated 3300-year tradition, it is easy to understand the challenge facing Osler. Estimated date ascertained from "Introduction to Leviticus," *New International Version Archeological Study Bible* (Grand Rapids: Zondervan, 2005), 155.
[80] Morrow, "Leprosy," 612.
[81] BALTIMORE CITY CIRCUIT COURT (Equity Paper A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281, Stenographer's Transcript, 69.
[82] Angela Ki Che Leung, *Leprosy in China: A History* (New York: Columbia University Press, 2008), 160.

"rotting bodies, decaying and putrid flesh, poisoned blood, leprous bodies and leprous souls."[83] Congress's passage of the act probably did more to support than alter the public's impression of the disease.

In the last decade of the nineteenth century, the public became captivated with the case of Joseph de Veuster, also known as Father Damien, a Belgian Catholic missionary who went to work with lepers in Hawaii in 1873. Unfortunately for the evangelist, he contracted leprosy from the patients with whom he was working and died in 1889. Father Damien's death caused considerable stir and a series of sensationalized newspaper accounts, biographies, and memoirs. Damien was one of a very small number of missionaries and religiously-affiliated leprosarium workers who caught the disease; nevertheless, the public was fixated with case because of the possibility of contagion. It seemed to justify fears that leprosy could be easily spread.

If Baltimoreans or the residents at Fairfield had forgotten Father Damien's case by the mid-1890s, they would have had their memories jogged upon reading an account in the *Sun* of Dr. H. Allen Tupper's trip to Hawaii, complete with a write-up of his impressions on the island's leper colony and Father Damien's still-resonant legacy.[84] The fear of leprosy via Hawaii remained relevant in the later 1890s, with Osler noting in his article on Sansone that "[i]n the question of the annexation of Hawaii the danger of leprosy also has come up." As he attempted to do before the court and in his statement to the *Sun*, Osler expressed an opinion that leprosy would not become an issue in the United States.[85]

Baltimoreans would also have been familiar, particularly after it was discussed in the *Sun*, with leper colonies in Minnesota, New York, and Louisiana. Minnesota's lepers had been brought from Norway in the mid-1800s. Their population was decreasing by the latter half of the

[83] Kraut, *Silent Travelers*, 83.
[84] "A Germ of the Ocean: Dr. H. Allen Tupper's Impressions of Hawaii" *Baltimore Sun*, November 23, 1895.
[85] Osler, "Leprosy in the United States," 49.

century, and they had in fact been released by the time McShane attempted to remove Sansone there.[86] The state of Louisiana opened the Louisiana Leper Home in 1894 near the town of Carville. Though Charity Hospital in New Orleans had been treating leprous patients since the 1850s, America's increasing presence on the international scene during the second half of the nineteenth century drew greater attention to previously discussed fears of leprosy.[87] In 1896, the state handed the failing hospital over to the Sisters of Charity, an order of nuns who immediately began enacting reforms.[88] It soon became the most famous leprosarium in the country.

Generally, public perception had consistently lagged behind leading research for much of early modern and modern history, often with frightening results. In the 1780s, a "Doctors' Mob" in New York City attempted to lynch an anatomist.[89] As the nineteenth century developed, strong anti-elitist trends led to a severe backlash of the American public against lawyers, doctors, and high church ministers. In medicine, this led to the rise of the Thomsonian school, a system focusing on botanic remedies that had established itself in every eastern state by the 1830s. Thomsonians asserted that, when it came to issuing medical treatment, "people are certainly capable of judging for themselves."[90] As late as the 1910s, Mary Mallon, alias "Typhoid Mary," stubbornly refused to believe doctors' assertions that she was a healthy carrier of typhoid infecting others with the deadly condition.[91] Even within the medical profession, many findings

---

[86] Wesley W. Spink, *Infectious Diseases: Prevention and Treatment in the Nineteenth and Twentieth Centuries* (St. Paul, MN: North Central Publishing Company, 1978), 160. The colony being closed is mentioned in "Dr. Jones is Puzzled" *Baltimore Sun*, August 10, 1898.
[87] Michelle Therese Moran, "Colonizing Leprosy: Imperialism, Patients, and the Politics of Public Health in Hawai'i and Louisiana" (PhD diss., University of Illinois, 2002), 124.
[88] Ibid., 129. It is possible that the sisters were still in the midst of establishing themselves in early 1897 when McShane attempted to contact them.
[89] Stevens, *American Medicine*, 21.
[90] Nathan Hatch, *The Democratization of American Christianity* (New Haven: Yale University Press, 1989), 29.
[91] Julie M. Fenster, *Mavericks, Miracles, and Medicine: The Pioneers Who Risked Their Lives to Bring Medicine into the Modern Age* (New York: Carroll and Graf Publishers, 2003), 117. One of the best book-length treatments of Mallon's life remains Judith Walzer Leavitt's *Typhoid Mary: Captive to the Public's Health*, though there are a number of books and articles written on her. Even television chef Anthony Bourdain, approaching her life from a cook's perspective, has treated the subject. See Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health*

did not immediately catch. Ignaz Semmelweis' finding in 1847 that obstetricians who washed their hands reduced deaths of puerperal (or childbed) fever from eighteen percent to one percent was not accepted until Louis Pasteur discovered bacteria in 1879.[92]

Considering the wide-ranging public knowledge of leprosy in the late 1800s, one can reasonably assume that the residents of Fairfield had an acute knowledge of the presence of the disease. That knowledge, coupled with their impression of the disease as extremely contagious and deadly, placed them in diametric opposition to the general consensus of medical knowledge at the time. This difference put the court in a precarious position, attempting to gratify both the scientific truths of their time and the public they knew would be reluctant to accept them.

D. Nineteenth Century Public Health Laws: Medical Knowledge v. Public Perception

Before analyzing the judicial balance of medical opinion and public perception in infectious disease cases, we should establish how the public health laws that empowered the government to protect public welfare also struggled with this balance. As mentioned above, the nineteenth century in America and in Baltimore was marked with significant breakthroughs in terms of the medical profession and medical knowledge. However, it was also a time of significant public apprehension towards those breakthroughs and the medical profession generally. The conflict between these two perspectives seemed to come to a head in the public health laws developing in cities and states around the country in the nineteenth century.

The development of Baltimore City and Maryland state public health laws are prime examples of this conflict. On the one hand, the laws were influenced by scientific advancements, but on the other hand there was often a considerable lag between medical breakthroughs and

---

(Boston: Beacon Press, 1995); Anthony Bourdain, *Typhoid Mary: An Urban Historical* (New York: Bloomsbury, 2001).

[92] Fenster, *Mavericks, Miracles, and Medicine*, 76, 90.

incorporation of these breakthroughs into the laws.[93] One reason is the susceptibility of lawmakers to public fears and apprehensions. Public opinion is often influenced by antiquated ideas and fears. As elected officials, lawmakers have to be sensitive to their constituents' traditional and religious beliefs even if they may be less than compatible with scientific advancement.[94] A second reason is the lack of sophistication of the lawmakers themselves. Lawmakers are not always tapped into progressive medical breakthroughs.[95] Tuberculosis in Philadelphia is a prime example of this lag. Throughout the nineteenth century medical and political officials in Philadelphia went back and forth on the true contagiousness of the disease, resulting in no government actions to limit the disease until 1930.[96] This disconnect is bridged as society becomes more affluent and sophisticated. A more sophisticated society elects more knowledgeable lawmakers who are tapped into the contemporary medical scene.[97]

Baltimore's initial public health laws, Ordinances 11 and 15 passed in 1797, empowered the city government to take government action against contagious and infectious diseases. Ordinance 11 was intended to prevent the spreading of "pestilential and other infectious diseases" in the city.[98] The Ordinance also defined a public nuisance in the city and established a Health Department with nine commissioners. The commissioners were given the duty to prevent

[93] William Travis Howard, *Public Health Administration and the Natural History of Disease in Baltimore, Maryland 1797-1920* (Washington: Carnegie Institution of Washington, 1924), 107.
[94] Ibid., 105.
[95] Ibid., 148. "Long years elapsed after it had been shown that cholera and typhoid fever are commonly spread by water and after it had been proven that these diseases and diphtheria and scarlet fever are often carried by milk, before such knowledge was reflected in the conceptions and activities of the health department." Ibid.
[96] Gretchen A. Condran et al., "The Decline of Mortality in Philadelphia from 1870 to 1930: The Role of Municipal Services" in *Sickness & Health in America*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison: The University of Wisconsin Press, 1997), 457.
[97] Howard, *Public Health Administration*, 105.
[98] Ibid., 48-49. At the end of the eighteenth century the following diseases were considered infectious: malarial fevers attributed to decaying vegetable matter. While the following diseases were classified as contagious diseases: venereal diseases, leprosy, the plague or the classical pest, elephantiasis, ophthalmia, small-pox, scarlet fever, measles, whooping cough, hydrophobia, and mumps. At that time, infectious diseases were thought to be spread through decaying matter, while contagious diseases were spread by human contact. Ibid., 39.

nuisances in the city.[99] Ordinance 15 further expanded on the commissioners' duties and created city sanitation duties including cleaning sidewalks, the beginning of garbage pickup by the city, and municipal street cleaning.[100]

In 1801, the City gave the commissioners the power to quarantine individuals in order to prevent the spread of contagious disease. The commissioners were given "full power to remove any person afflicted with contagious disease to a hospital or other place" and were given the authority to quarantine an infected house. [101] In 1853, The City created the health warden position and stationed one in each district. The health warden was tasked with reporting nuisance dangers in his district to help prevent the spread of disease.[102]

Following these ordinances, the city's public health laws fluctuated with changing medical views. Fluctuations included modifying laws as a result of new scientific views on the causes and impacts of disease and shifting the focus of prevention from sanitation to medical treatments such as vaccination. Underlying all these changes, however, was the lag time between discovery of scientific advancement and incorporation of advancement into the public health laws. In addition, there was a move away from laws focusing on government responsibilities toward laws outlining private duties and responsibilities in preventing disease.

Throughout the nineteenth century doctors and scientists uncovered the true impacts and causes of infectious and contagious diseases. As a result, laws dealing with the prevention of certain diseases seemed constantly in flux. For example, reportable disease lists began in 1820 when the City required physicians to report cases they diagnosed of a limited number of

[99] Ibid., 48-49.
[100] Ibid.
[101] Ibid., 56.
[102] Ibid., 55.

contagious diseases. Failure to report resulted in a penalty of $100 for noncompliance.[103] In 1869, smallpox was removed from the list because it was believed the disease was no longer a threat.[104] However, in 1882, smallpox was back on the list of reportable diseases along with cholera, yellow fever, malignant diphtheria, and scarlet fever. In 1890, 1895 and 1896 the list of reportable diseases expanded to include a larger number of diseases. Leprosy was first included on the 1920 list.[105] The expansion of the list of diseases that had to be reported is an example of how the laws changed as views of disease changed.

As mentioned above, the law was not always quick to catch up with medical breakthroughs, and laws regulating the spread of infectious disease were no exception. For example, the Baltimore City quarantine laws were modified numerous times during this period, much like the reportable disease registries. In the late eighteenth century, yellow fever was thought to be a contagious disease that was brought into Baltimore City through the ports. As a result of the numerous yellow fever outbreaks at that time, the early quarantine laws were drafted based on these impressions and were not concerned with the spread of other diseases.[106]

As early as 1797, however, doctors were reporting that yellow fever was not contagious but rather infectious and originated locally.[107] Throughout the early nineteenth century, physicians recommended the repeal of quarantine laws because they were ineffective in preventing yellow fever.[108] The lawmakers finally responded to the doctors' recommendations in

[103] Ibid., 56.
[104] Ibid., 56; *see also* Judith Walzer Leavitt, "'Be Safe, Be Sure' New York City's Experience with Epidemic Smallpox" in *Sickness & Health in America*, ed., Judith Walzer Leavitt and Ronald L. Numbers (Madison: University of Wisconsin Press, 1997).
[105] Howard, *Public Health Administration*, 56-58.
[106] Ibid., 83-90. The early laws only required short term quarantine in the summer months because that is when yellow fever hit and because yellow fever had a short incubation period. Ibid.
[107] Ibid. Outbreaks always started in Fells Point where there was a lot of standing water and decaying vegetal matter. Ibid.
[108] Ibid. Actually the quarantine of vessels for extensive periods of time in the hot summer may actually be contributing to disease. Ibid.

1820, almost 20 years after the initial recommendation, by repealing the City's quarantine laws. In 1826, the City reinstated the quarantine laws because of new fears of smallpox and typhus fever from new immigrants.[109] Finally, the quarantine laws were rewritten without specific diseases in mind, instead giving the health commissioners discretion on how to prevent the spread of disease. In 1880, the federal government instituted uniform quarantine laws for all ports that preempted all Baltimore City local laws. [110]

In regards to quarantine laws, there were also times where the public never accepted medical opinions and as a result, the laws never incorporated these opinions. During the 1832 cholera outbreak in the city lawmakers were considering quarantine measures to prevent the spread of disease. Doctors in the city recommended against quarantine measures because the disease was not in fact contagious. However, notwithstanding the medical recommendation, lawmakers instituted quarantine measures because of opposition from the public.[111]

As discussed above, initial City public health laws were focused on sanitation in the form of cleaning up the public and private realm. These laws continued to be important and continued to develop throughout the nineteenth century. During this time medical treatments also became widely accepted by the medical community as alternative methods to prevent disease.[112] Much like the quarantine laws, in some situations, these medical treatments were available for decades before they were used, primarily because of the public's inability to accept the new treatment methods.[113]

---

[109] Ibid. The City distinctly stated that the new quarantine laws were not to prevent yellow fever. The City criticized other localities that still had yellow fever related laws. Ibid.
[110] Ibid., 90-96.
[111] Ibid., 90.
[112] This is true in other cities in the United States. Disease control in Philadelphia also shifted from pure sanitation efforts to a focus on medical treatment in the form of vaccinations. Condran, "The Decline of Mortality in Philadelphia from 1870 to 1930, 457,
[113] Leavitt, "'Be Safe, Be Sure' New York City's Experience with Epidemic Smallpox", 411.

The discovery of the smallpox vaccine is an example of a medical breakthrough that revolutionized prevention of disease in the country and the City of Baltimore once it was finally widely accepted and incorporated into law.[114] The smallpox inoculation was available as early as the mid-eighteenth century in cities like New York. The inoculation would introduce a mild case of smallpox under the skin to build up antibodies. It was quite dangerous because inoculated individuals became contagious and could pass on the disease to others. Thus, the inoculation did not become widely accepted. In 1801, a doctor in England discovered a smallpox vaccine where an individual would be injected with cowpox. Vaccinated people were immune to smallpox but did not pass on the disease. Despite this discovery, there were strong public movements in cities across the country against the vaccine because of the misconception that it was just as dangerous as inoculation. This opposition often convinced lawmakers not to incorporate the vaccine into disease prevention.[115]

It was not until the mid-nineteenth century that Baltimore City and the State of Maryland began integrating the vaccine into smallpox prevention. In 1882, Baltimore City health commissioners were given the power to order the vaccination of any individual who would not voluntary submit to a vaccination against smallpox. In addition, the state of Maryland passed a law in 1864 that every parent had to vaccinate their child before their first birthday. Children who had not been vaccinated could not attend school, and physicians who did not vaccinate could be penalized.[116]

At times more than just medical breakthroughs caused public apprehension of new treatments; sometimes the lack of public acceptance was due to the fear that such a treatment

[114]Ibid., 410-11.
[115] Howard, *Public Health Administration*, 55. For more on smallpox in the late eighteenth century, see Elizabeth A. Fenn, *Pox Americana: The Great Smallpox Epidemic of 1775-82* (New York: Hill and Wang, 2001).
[116] Howard, *Public Health Administration*, 76.

would impinge on an individual's constitutional right. A primary example of this was the anti-smallpox vaccination movement in New York City during this time. The anti-vaccination movement argued that compulsory vaccination violated personal liberties and was too much government intervention in a citizen's private life. New York lawmakers listened to the public concerns and focused on educating the public about the benefit of the vaccine instead of instituting mandatory vaccination.[117]

The Supreme Court settled this issue in *Jacobson v. Massachusetts*. The Supreme Court ruled that compulsory vaccinations were not unconstitutional because private liberties were no more important than public safety, but the state could not vaccinate someone against his or her will.[118] The state could arrest an individual who refused to get vaccinated, but it could not forcibly vaccinate the individual. Thus, smallpox and other diseases still spread as immigrants continued to refuse to get vaccinated. In the end, public health officials in New York and cities around the country passed laws conditioning school attendance on vaccination.[119] As mentioned above, Baltimore City instituted a similar law in regards to vaccination and school attendance. [120]

The Progressive Era also saw a movement towards more personal responsibilities in terms of the protection of personal and public health. The public health law realm was no exception to that trend. In the late-nineteenth century, the City passed laws requiring private individuals to do their part in preventing disease. Beginning in 1886, private homes had to provide suitable garbage disposal containers. Individuals had to dispose of their garbage in those

[117] Leavitt, "'Be Safe, Be Sure' New York City's Experience with Epidemic Smallpox , 410-13. In *Mayor v. Fairfield*, Mary Sansone's personal liberties were not considered as an issue in adjudicating the case. It was a given that as an infected individual, the government had the power to take away her personal liberties to protect the greater community. Courts around the country have ruled that an individual sick with an infectious disease is a nuisance, every nuisance is "indictable," and the government can act against it. Boom v. City of Utica, 2 Barb. 104, *4 (N.Y. Sup. 1848).
[118] 197 U.S. 11 (1905).
[119] Leavitt, "'Be Safe, Be Sure' New York City's Experience with Epidemic Smallpox" , 410-13.
[120] *See supra* note 116 and accompanying text.

containers and were prohibited from throwing their refuse into the street. Around the same time, the City passed laws requiring that private homes be maintained in habitable conditions, including a suitable roof, good and sufficient number of water closets, and keeping the home and surrounding environment free of garbage and refuse. The City hired building and plumbing inspectors to make sure the laws were being followed. In the early-twentieth century, these laws were codified into a comprehensive building code for the City. [121] In addition, the state of Maryland made it a crime to expose others to disease and to rent a space in your home without disinfecting that space after a diseased individual had resided there.[122]

This movement towards more personal responsibility did not stop city and state governments from maintaining the public power to prevent disease, even at the expense of private rights. Maryland did not shy away from the public power. The state of Maryland passed a law in 1882 that gave city health authorities the power to disinfect private property.[123]

In the development of the public health laws underlying the *Mayor v. Fairfield* case, lawmakers often did a preliminary balancing of current scientific advancements and public perception of those advances. Consequently, the public health laws were written with these conflicting views in mind. However, this fact did not prevent the courts from further balancing these interests during proceedings interpreting the public health laws. Judge Dennis' and McSherry's opinions were no exceptions. The judges considered the public perception of leprosy in deciding *Mayor v. Fairfield* case.

E. Judicial Interpretation of Infectious Disease Cases

During the nineteenth century, courts around the country heard numerous cases involving new public health laws. The courts also found themselves reviewing these laws with public

[121] Howard, *Public Health Administration*, 66.
[122] Ibid., 76.
[123] Ibid.

opinion of medical breakthroughs in mind. Courts seemed to analyze harmful nuisances and disease from the starting point of public perception and not from medical knowledge of the event. *Mayor v. Fairfield* is a prime example of these numerous considerations of the court.

In *Mayor v. Fairfield*, the court stressed how the standard for determining a nuisance should not be whether the disease was actually contagious but "whether, viewed as it is by the people generally, its introduction into a neighborhood is calculated to do serious injury to the property of the plaintiff."[124] Thus the court looked at public fear of leprosy and how that would impact Fairfield's property values despite the fact that the disease is not actually contagious. "There are modern theories and opinions of medical experts that the contagion is remote… but the popular belief of its peril…cannot in this day be shaken or dispelled by mere scientific asseveration or conjecture."[125] The court ruled that in determining a nuisance one needed to look at how the public portrayed the harmful event and not necessarily the actual impact of that event.[126]

It appears that the *Fairfield* court's interpretation of public perception in the determination of a nuisance was in line with a general judicial trend. In *Birchard v. Board of Health of City of Lansing*, the Supreme Court of Michigan held that a pest house could not be placed in a crowded district because even though "there might be no actual danger if properly conducted…their maintenance in close proximity to the home would create such dread and fear in the mind of the normal person as would destroy… the property rights of the plaintiff."[127] Similarly, in *Kirk v. Wyman*, the Supreme Court of South Carolina held that the facilities within which the board of health was planning to house a female leper were unfit. Despite the ruling,

[124] Mayor v. Fairfield Improvement Co., 39 A. 1081 (Md. 1898).
[125] *Id.* at 1084.
[126] *Id.*
[127] 169 N.W. 901, 901 (Mich. 1918). This case actually cited Fairfield as a leading authority on this issue. *Id.*

the court noted that if the facilities were fit, the board of health had every right to quarantine the plaintiff, even though her form of leprosy was only slightly contagious, because of how the particular disease was regarded by the public.[128]

Thus, just like lawmakers, judges were aware of the general public's fear of new medical advancements and took that into account when ruling on infectious disease nuisance cases. Judge Dennis and McSherry were not constructing novel approaches to nuisance law when deciding the *Mayor v. Fairfield* case.

VI. CONCLUSION

Like any legal case, *Mayor v. Fairfield* did not occur in a vacuum. Playing upon it were wider and farther-reaching legal, historical, and social trends. The case took place at the end of a century wrought with contagious and infectious diseases that had devastating effects on the American people. An ill-informed public, unwilling to break with its traditional understanding of leprosy, associated Sansone's condition with more traumatizing epidemics. The century also saw a great upheaval in medical knowledge as doctors strove to introduce their findings to an unprepared world. As evidenced by its inconsistent application of scientific and medical understanding throughout the century, law often had to adopt a role of reconciliation between the divergent interests of public and medical beliefs. As a corollary, the arrival of the Progressive Era at the turn-of-the-century brought greater focus on expert opinion (read: that of the doctors) and the public's responsibility for the maintenance of a healthy society, initiating a legal shift from the preeminence of private property to public health rights. *Fairfield* demonstrates the way that these loosely associated trends were beginning to—but had not fully—come together by 1897. In so doing, it sharpens our impression of the way that law cannot be disassociated from the times and opinions in which it is decided and made.

[128] 65 S.E. 387, 391 (S.C. 1909).

BIBLIOGRAPHY

BALTIMORE CITY CIRCUIT COURT (Equity Papers A) Fairfield Improvement Co. v. Mayor and City Council of Baltimore, 1897, MSA T53-281.

Birchard v. Board of Health of City of Lansing, 169 N.W. 901 (Mich. 1918).

Boom v. City of Utica, 2 Barb. 104 (N.Y. Sup. 1848).

Bourdain, Anthony. *Typhoid Mary: An Urban Historical*. New York: Bloomsbury, 2001.

Bramucci, Nancy. "Epidemics in Maryland" *Medicine in Maryland 1752-1920* http://mdhistoryonline.net/mdmedicine/cfm/dsp_epidemics.cfm.

Che Leung, Angela Ki. *Leprosy in China: A History*. New York: Columbia University Press, 2008.

Condran, Gretchen A., Henry Williams, and Rose A. Cheney. "The Decline of Mortality in Philadelphia from 1870 to 1930: The Role of Municipal Services" in *Sickness & Health in America*, ed. Judith Walzer Leavitt and Ronald L. Numbers. Madison: The University of Wisconsin Press, 1997.

Crooks, James B. "Politics of Reform: The Dimensions of Baltimore Progressivism." *Maryland Historical Magazine* 71 (Fall 1976): 421-427.

Diamond, Philip. "An Environmental History of Fairfield/Wagner Point." (Paper based on the collective research of the faculty and students in the Fall 1997 Building Baltimore Seminar, University of Maryland School of Law, 1998).

Fenster, Julie M. *Mavericks, Miracles, and Medicine: The Pioneers Who Risked Their Lives to Bring Medicine into the Modern Age*. New York: Carroll and Graf Publishers, 2003.

Hatch, Nathan. *The Democratization of American Christianity*. New Haven: Yale University Press, 1989.

Harvey, Abner McGehee. *The Association of American Physicians 1886-1986: A Century of Progress in Medical Science.* Baltimore: William and Wilkins, 1986.

Howard, William Travis. *Public Health Administration and the Natural History of Disease in Baltimore, Maryland 1797-1920*, Washington: Carnegie Institution of Washington, 1924.

"Introduction to Leviticus." *New International Version Archeological Study Bible*. Grand Rapids: Zondervan, 2005.

Jacobson v. Massachusetts, 197 U.S. 11 (1905).

Johns Hopkins Medical Archives, "Biography" http://www.medicalarchives.jhmi.edu/osler/biography.htm.

Kerson, Toba Schwaber. "Almshouse to Municipal Hospital: The Baltimore Experience." *Bulletin of the History of Medicine* 55 (1981): 215.

Kirk v. Wyman, 65 S.E. 387 (S.C. 1909).

Kraut, Alan M. *Silent Travelers: Germs, Genes, and the "Immigrant Menace."* New York: BasicBooks, 1994.

Leavitt, Judith Walzer. *Typhoid Mary: Captive to the Public's Health*. Boston: Beacon Press, 1995.

Leavitt, Judith Walzer. "'Be Safe, Be Sure' New York City's Experience with Epidemic Smallpox" in *Sickness & Health in America* in ed., Judith Walzer Leavitt and Ronald L. Numbers. Madison: University of Wisconsin Press, 1997.

Mayor v. Fairfield Improvement Co., 39 A. 1081 (Md. 1898).

Miller, Joseph M. "Vignette of Medical History: Lazaretto Point." *Maryland Medical Journal* 42 (November 1993): 1123-1125.

Moran, Michelle Therese. "Colonizing Leprosy: Imperialism, Patients, and the Politics of Public Health in Hawai'i and Louisiana." PhD diss., University of Illinois, 2002.

Morrow, Prince A. "Leprosy." in *Twentieth Century Practice: An International Encyclopedia of Modern Medical Science by Leading Authorities of Europe and America Volume XVIII*. New York: William Wood and Company, 1899.

Olson, Sherry H. *Baltimore: The Building of an American City*. Baltimore: Johns Hopkins University Press, 1980.

Osler, William. "Leprosy in the United States, With a Report of a Case." *Bulletin of The Johns Hopkins Hospital* 9 (March 1898): 47-49.

Population from U.S. Bureau of the Census. "Population of 24 Urban Places: 1790." http://www.census.gov/population/www/documentation/twps0027/tab02.txt.

Powell, John M. "History of Baltimore: 1870-1912" in *Baltimore: Its History and Its People, Volume I—History*. Clayton Colman Hall, ed. New York: Lewis Historical Publishing Company, 1912.

Rosenberg, Charles E. *The Cholera Years: The United States in 1832, 1849, and 1866*. Chicago: The University of Chicago Press, 1962.

Rosenkrantz, Barbara Gutmann. “Cart before Horse: Theory, Practice and Professional Image in American Public Health, 1870-1920.” *Journal of the History of Medicine and Allied Sciences* 29 (1974): 141-174.

Scharf, John Thomas. *History of Baltimore City and County From the Earliest Period to the Present Day: Including Biographical Sketches of their Representative Men*. Philadelphia: Louis H. Everts, 1881.

Spink, Weley W. *Infectious Diseases: Prevention and Treatment in the Nineteenth and Twentieth Centuries*. St. Paul, MN: North Central Publishing Company, 1978.

Stevens, Rosemary. *American Medicine and the Public Interest*. New Haven: Yale University Press, 1971.